NATIONAL HEALTH POLICY
FORUM

Information and Incentives:

Improving the Health of New York City's Low-Income Population

SITE VISIT REPORT

NEW YORK, NEW YORK

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THE GEORGE WASHINGTON UNIVERSITY
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Contents

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BACKGROUND

No other U.S. city can rival New York City (NYC) for population size and density, cultural diversity, and cost of living. The city comprises five boroughs—Manhattan, Brooklyn, Queens, The Bronx, and Staten Island. Taken separately, Brooklyn and Queens would be the fourth- and fifth-largest cities in America, as one presenter noted during the site visit. Taken together, all five boroughs form by far the most populous metropolitan area in the United States, with almost 8.4 million people in 2009.[1] The population is twice that of Los Angeles, the second-largest city, and larger than Chicago, Houston, Phoenix, and Philadelphia combined.[2] As has been the case for centuries, NYC's population is also notable for the large number of foreign-born residents who live in and continue to arrive there from all over the globe. According to recent estimates, 36 percent of NYC's population was not born in the United States, and this foreign-born population has extremely diverse origins.[3] NYC's cost of living is among the highest in the United States. In part because of the city's density, items and services, including housing, food, and transportation, are expensive there. NYC has a bimodal population of the very wealthy and, in much larger numbers, the poor. This distribution is masked in data on average income: NYC has a per capita income that is higher than the national average, but its households live in poverty at twice the rate (18.5 percent) of the national average (9.2 percent). New Yorkers who live just a few blocks from one another can face very different conditions (for example, housing and access to food) that can affect their health status.

The high costs of living and doing business in NYC have multiple implications in terms of the real levels of Medicaid eligibility, Medicaid costs, and overall health care costs. Programs, such as Medicaid, that use the federal poverty level (FPL) to determine eligibility do not take the local cost of living into account in that determination. As a result, although a New Yorker may not meet the poverty thresholds to qualify for Medicaid, her dollar does not go as far in NYC as a dollar in another city with lower prices. New York's Medicaid program is the most expensive in the United States per person, but the fee-for-service rates paid to physicians treating Medicaid beneficiaries have been found to be among the lowest in the country, relative to Medicare rates.[4] NYC also appears to have high per capita Medicare spending, but when input prices are taken into account, the city becomes a much more moderate-cost area compared to other cities. New York also has

high private insurance premiums. One study of 2010 health care costs for a family of four covered by employer-sponsored insurance found that NYC had the second-highest costs in the nation, without controlling for health status, input cost variation, or other factors.[5] However, a U.S. Government Accountability Office study of the Federal Employees Health Benefits Program preferred provider organizations' (PPOs') spending found that PPOs' payment to hospitals and physicians and overall PPO spending per enrollee in the NYC metropolitan area was among the lowest in the nation when controlling for health status and local input costs such as rent and wages.[6]

Hospitals have a tremendous presence in NYC, which is home to several large, world-renowned academic medical centers. The city also has as a range of safety net providers, from large multihospital systems to smaller community health centers (CHCs) that serve Medicaid enrollees and the uninsured. Some providers are independent and confined to a particular neighborhood; others are part of large, multiprovider systems that span more than one neighborhood or even multiple boroughs. Safety net providers rely heavily on public program payments for economic survival. They must respond to current payment incentives created by public payers and anticipate changes in policy, while serving all the medical needs of their patients. Providers in NYC must be prepared to serve a diverse population, which requires a corresponding cultural awareness and the availability of resources such as interpreters and translators. That is not a reality for most providers in places with populations more culturally and linguistically homogeneous.

New York State's Medicaid program covers 4.5 million people, making it the second-largest Medicaid program in the country, behind only California. More than 2 million people are enrolled in Medicaid in NYC alone. Managed care is mandatory for most Medicaid enrollees in NYC, but some populations, such as long-term care facility residents and those with serious and persistent mental illness, are not in managed care. As one speaker noted during the site visit, with its Medicaid eligibility levels set at 150 percent of the FPL for parents and 100 percent of the FPL for childless adults, New York is much closer to the new Medicaid eligibility levels in the Patient Protection and Affordable Care Act (PPACA, P.L. 111-148) than many other states. Even though New York State has a lower rate of uninsurance than the U.S. average, the more than 1 million uninsured in NYC constitute a group larger than the population of many American cities.

Against this backdrop, the site visit was focused on providers that deliver care to NYC's low-income population and on programs that providers and policymakers have designed and implemented to improve performance. Among these programs are (i) state, city, and private funding to support the adoption and use of electronic health records (EHRs) by primary care providers; (ii) incentives to support quality and efficiency improvements among various safety net providers; and (iii) initiatives to build healthy communities and improve population health.

Through a combination of consumer and payer demands and their own initiative, safety net providers have taken steps to identify quality deficiencies and improve the quality of care and service delivery to their patients. Health information technology (IT) adoption initiatives have been under way in New York for some years, within hospital systems, CHCs, and in the Primary Care Information Project (PCIP), across a broad base of small safety net practices. As the time approaches for stimulus funds to be made available to "meaningful users" of EHRs, physicians and hospitals are all considering their options and trying to position themselves advantageously. Exploring the challenges and the progress to date thus offered a valuable glimpse of the implementation issues brewing all over the country.

If New York can claim so many superlatives among U.S. cities, why make it a site visit destination for federal policymakers? By itself, NYC is a big piece of the federal health care pie and therefore worth a deeper look. For example, NYC's public hospital system alone receives more federal Medicaid disproportionate share hospital (DSH) and upper payment limit funding than 37 states. New York also offers real-time examples of federal policy (and federal investment) being played out on a large, complex, and dynamic stage. While it is impossible to capture the entire NYC health care market in a two-day si te visit (especially when the group only set foot in two boroughs), NYC offers instructive examples of providers and policymakers grappling with health policy issues that confront providers in health care markets all across the county. Though often not fully appreciated in federal policy discussions, the effect of scale and the idiosyncrasies and complexities of a marketplace are impossible to ignore in NYC. Visiting NYC providers makes one keenly aware that federal policies can have very different impacts, depending on the characteristics of a place, including size, density, and composition. Policy may have to play in Peoria, but it also has to work in the South Bronx and Chinatown and Washington Heights.

PROGRAM

The site visit began the morning of April 6, 2010, with an overview of health care in New York City, emphasizing state, city, and private efforts to deliver care to the city's low-income population. Perspectives on health IT adoption and use were offered by a panel representing the city health department, a service workers' union, and a network of community health centers. Site visit participants then walked from the United Hospital Fund to Bellevue Hospital, taking in the sheer volume of space given to health care delivery on First Avenue. A panel of corporate and hospital executives from the New York City Health and Hospitals Corporation (HHC) discussed the operations, challenges, and aspirations of the country's largest public hospital and health care system. A subway trip took visitors to the day's last stop, the Charles B. Wang Community Health Center in Chinatown, where administrators and clinicians described how its outreach and health IT programs were used in support of its clinical mission. A tour of the center followed.

Day two opened with a discussion among researchers and a managed care plan of Medicaid's role in improving care delivery and quality to a safety-net population. A consideration of neighborhood-level health intervention programs followed. The group then traveled to the Bronx for a presentation at Montefiore Medical System, a leader in community outreach, quality improvement, and health IT in a part of the city where economic, education, and cultural demographics present an ongoing challenge to the delivery system.

IMPRESSIONS

Safety Net Providers and Funding

Many institutions and providers that make up the health care safety net have a long history of providing care to New York's immigrant populations, the poor, and the un- and underinsured. The largest of these, HHC, serves 1.3 million New Yorkers every year, 450,000 of them uninsured. Although it is the most visible safety net provider, to varying extents all of the city's hospitals provide care to low-income and uninsured residents, as do community physicians and other providers throughout the city. NYC also has approximately 65 CHCs in neighborhoods throughout the five boroughs. These

centers are located in medically underserved areas and provide primary health care to anyone seeking it, regardless of ability to pay.

Funding for safety net providers in NYC comes from several government sources. Medicaid payments account for 34 percent of all hospital payments in NYC, compared to 14 percent in the rest of the state. NYC hospitals rely on Medicaid and Medicare DSH funding to provide supplemental payments to compensate for Medicaid shortfalls and caring for the uninsured. Graduate medical education (GME) funds are also a critical revenue stream for teaching hospitals. CHCs depend on grant funding from the Health Resources and Services Administration, but almost half of the CHC revenues in New York State come from Medicaid payments. Medicare, though not exclusively a source of funding for safety net providers, is an important source of revenue for NYC's safety net hospitals, as it is for most hospitals.

- NYC providers are accustomed to an active and strong city, state, and federal government role in funding safety net institutions and regulating providers. NYC providers seem to expect the government to play a role in shaping the health care market.
- Safety net institutions in NYC, in particular large, vertically integrated delivery systems, have the potential for real economies of scale.
- Safety net hospitals are dependent on Medicaid DSH funding and public insurance program payments. DSH funding for hospitals and low Medicaid physician fees have ossified the hospital-centricity of the delivery system for the safety net population. This makes alternate, nonhospital-based delivery models difficult to implement. GME payments have also contributed to this hospital-centricity by tying medical education payment solely to teaching hospitals.
- Historically, New York decided to structure Medicaid reimbursement to steer beneficiaries toward hospital care and away from Medicaid-only community practices that were seen as providing high volumes of low-quality care to Medicaid enrollees.
- Three of the four largest Medicaid managed care plans in NYC are hospital-sponsored prepaid health service plans. Participants wondered whether plans in this relationship have the leverage over providers to induce efficiency.

- CHCs have idiosyncratic relationships with large hospitals and specialty providers. In such a hospital-dominated market, CHCs must work to be part of the continuum of care that extends beyond their clinics. Getting specialty care for their uninsured primary care patients or information about the care they receive elsewhere can be difficult.
- CHCs seek to serve their communities by providing primary care to all patients who seek it. They also see themselves as having a secondary role of training clinic workers in the community to improve their job skills and employment prospects.

Supporting Quality of Care

New York is a leader in health information technology. Both the New York eHealth Collaborative and the NYC Department of Health and Mental Hygiene's PCIP are nationally recognized. The New York State Department of Health created a new executive position, deputy commissioner for health information technology transformation, in 2009 (and filled it with the former head of the eHealth Collaborative). There is widespread support for using health IT to advance quality of care. Some community organizations, notably the Institute for Family Health (IFH), have been at the forefront of health IT utilization, data collection and analysis, and quality improvement for many years.

- Some safety net providers in New York are quite advanced with respect to quality improvement (QI) and health IT. Among the reasons are the following:

  Size – HHC, for example, has 11 acute care hospitals, four skilled nursing facilities, six large diagnostic and treatment centers, and more than 80 community-based clinics, enabling it to generate data sufficient to support QI projects. An EHR system, developed in-house over many years, allows benchmarking and comparison among facilities, disease surveillance, and trend analysis.

  Leadership and governance – An organization that makes a success of health IT implementation and/or develops a culture that values QI likely can point to commitment at the top. In some cases, this may imply a top-down management style and the power to impose IT and QI requirements; in others, a visionary leader is able to bring an organization to share that vision. IFH went paperless in an all-at-once implementation of EHRs in 2002; under

its president's guidance, IFH doctors have since developed the capacity to marshal their data to identify trends and outbreaks, sharing data with the city health department as well as informing their own practice. Data are uploaded from IFH practices daily to the city health department, an innovation that participants thought could be replicated in most cities, given available funding.

Government assistance – Public monies have been made available at various levels of government to support providers in adopting health IT and using it to further QI efforts. For example, PCIP has enrolled more than 2,500 physician practices. The U.S. Health Resources and Services Administration has made health IT–related grants to CHCs.

- Health IT initiatives proliferate, but interoperability remains a gleam on the horizon. The successes hospital systems and others can point to in using health IT to drive QI are largely intramural. Vendors do not see incentives that would move them to work toward connecting organizations in the community, particularly where a hospital system or clinic has signed up with a competitor. Participants were dismayed to find that this was true, even though there were several health information exchanges within NYC.
- Successful health IT adoption and deployment is not a one-time proposition. It requires considerable investment in training as well as the initial outlay for hardware and software. As one chief financial officer observed, "Training is forever," meaning not that its effect lasts forever but that it must go on forever. Trained staff, often courted by other organizations, will turn over. System specifics will change. Clinicians' data requirements will grow more sophisticated. Standards will be imposed. All along, trend analysis, performance measurement, and QI are only as good as the data they are built on.
- Feedback to providers on the quality of their performance is generally welcome if the source is trusted. PCIP reports that its participating physicians are pleased to have access to benchmark and personal performance data.
- Knowledge of a particular community can aid in targeted prevention and treatment activities. For example, the New York Academy of Medicine's Center for Urban Epidemiologic Studies uses community-based participatory research as the basis for identifying

community-level health issues and forming partnerships with community, public health, and academic organizations to address them. The Charles B. Wang Community Health Center is able to target programs to the 18 percent of its community who suffer from hepatitis B.

Hospitals

New York is home to several large, not-for-profit, teaching hospitals. Many of these are tertiary and quaternary care centers with national and even international name recognition. And all but of the 62 hospitals in NYC is a teaching hospital. The relationships between the medical schools and the hospitals—and the relationship between the streams of funding for teaching, research, and services—are not always easy to discern. In addition to providing specialized acute inpatient care, many hospitals diversify their presence by maintaining vertically integrated health systems that provide long-term care, ambulatory care, home health, and other services; they also operate health plans.

- Teaching hospitals have clout on a state and national level. These institutions are well respected and sought after by patients and faculty and by insurers, who will pay higher rates to prestigious "brand-name" hospitals. Participants speculated that there are so many of them that competition among teaching hospitals may be possible, unlike in some markets.
- Some participants wondered how to change medical education, which is seen as integral to delivery system transformation, given the size and political and economic power of the current academic medical institutions and their investment in specialty medicine. Some speculated that it may not be that we need fewer specialists trained in NYC, but that academic medical centers need incentives to train more primary care providers in addition to specialists to increase the ratio of primary care providers to specialists. Given the power of hospitals, panelists noted the challenge of moving more resident training out into community practice. Medical residents form a large core, 27 percent, of the physician workforce in NYC, according to one speaker. The city's large, academic, specialty-oriented institutions that train residents seem to be at odds with the primary-care–based delivery system reforms that many policymakers envision. Yet, given its size and density, NYC is possibly

an ideal training ground for specialists. It may be one of the few places that can provide a large-enough patient population to hone specialists' skills.

- Getting a handle on optimal capacity in a geographic area requires consideration of many factors and the balancing of efficiency expectations with surge capacity for times of disaster and disease outbreaks. It also requires a realistic assessment of the cost of caring for people living in and near poverty. Reducing the number of hospitals is politically difficult because they are the source of many jobs (and many union jobs) and because there is some neighborhood loyalty to certain institutions, even if they are in perennial financial distress. One hospital mentioned that it was actively considering how it could be optimally configured to improve efficiency. (It should be noted that, in November 2006, the Commission on Health Care Facilities in the 21st Century [also known as the Berger Commission] issued recommendations to restructure the hospital and nursing home systems in New York State and to reduce excess capacity; those recommendations were implemented. For additional information see the final report at www.nyhealthcarecommission.org/final_report.htm.)
- New York hospitals may be able to become more efficient. They have lengths of stay, on average, one day longer than the national average. According to a panelist, the reasons for this are unknown.
- New York hospitals have had clear trends in profitability over the past several years. Large academic medical centers have become more profitable. Many small hospitals and safety net hospitals, in contrast, have negative margins. These facilities see few patients on whom they can make a profit, and they cannot fetch high rates from private insurers. Participants wondered whether more will close or consolidate with other institutions and whether there might be some advantages to this in terms of overall health spending in the city.
- Academic medical centers may have different levels of commitment to the poor and underserved in the communities surrounding their institutions. This could be a function of mission, leadership, and culture. Some hospitals may decide that, by virtue of their competitive position, they will maximize the share of patients with private insurance; others make explicit decisions to assess community need and provide services that the community requires.

Competition and Collaboration

NYC's 62 hospitals would suggest it should be a hotbed of competition, particularly given the presence of half a dozen academic health centers. But a countervailing neighborhood loyalty is at work (demonstrated by emphatic complaints, when St. Vincent's Hospital closed, that the nearest alternative was "30 blocks away").

- Financial incentives, in NYC as elsewhere, favor competition over collaboration; however, competition does not necessarily yield lower prices or higher quality. Hospitals with insured patients and high-margin procedures tend to prosper. Newly gentrifying neighborhoods are likely to attract multiple competing outpatient facilities designed to channel patients to various hospitals. Hospitals can choose to engage with their communities and collaborate with other providers, as Montefiore is doing in the Bronx, but they must have achieved financial stability in order to support it.
- What hospital systems present as care coordination and longitudinal patient care may also be viewed as a strategy to control all stages of care delivery and ensure that referrals stay within the system. Hospital systems, notably HHC, have achieved a significant degree of vertical integration but have given less attention to horizontal integration or nurturing relationships with other safety net providers.
- Hospitals in which Medicaid accounts for a significant share of the patient mix have collaborated to establish and support the Medicaid managed care plan HealthFirst. However, they do not seem to use joint ownership as the basis for further collaborative efforts, such as quality improvement initiatives on a plan-wide scale. One panelist noted that it was not realistic to expect Medicaid managed care organizations to change the hospital-based, specialty-oriented delivery system in NYC, in part because there are too many Medicaid managed care organizations and because those with potentially significant leverage because of market share are controlled by hospitals. A participant observed that this dynamic presages the question of whether Medicaid managed care organizations can use increased market power from eligibility expansions to influence the delivery system and the cost of care for Medicaid enrollees.

- Some community-based organizations express distrust about working with large hospitals, in terms of both information sharing ("once the patient is in the hospital, we hear nothing") and follow-up patient care. Discharge planning and communication with a patient's primary care provider are weak. There seems to be a disconnect between hospital-based clinic doctors and their community counterparts as well.
- Health IT initiatives such as PCIP are attempting to make performance-based information available to front-line providers but have not yet tackled communication among different vendors' EHR systems.

Effects of Health Reform

The PPACA passed just two weeks prior to the site visit. This landmark legislation, intended to reduce the number of uninsured nationally and test some payment reforms through the Medicare program, was an ever-present context for all of the presenters. They discussed how they will respond to the incentives in the current environment while also anticipating the large coverage expansions coming in 2014.

- Hospitals are working to position themselves for business in the run-up to and after reform. They are trying to be responsive to the vision for delivery system reforms that has been articulated by policymakers (for example, accountable care organizations), but they must also respond to current payment incentives to deliver more, higher-intensity services. Some participants observed that this is an example of why payment reforms are necessary to achieve delivery system reforms. Emphasis on prevention and reducing readmissions must be accompanied by incentives to counter fee-for-service incentives to fill beds. Representatives from one hospital mentioned that the hospital is exploring the potential of new demonstration authority to facilitate care integration and improve health outcomes for entire geographic areas.
- Some safety net institutions are concerned about their competitive position in a postreform era in which the newly insured may have greater choice of providers. They wonder whether they will lose current patients who may have the option of getting care at

one of the city's more prestigious hospitals. One safety net hospital executive referred to this phenomenon as "aspirational medicine." Safety net institutions also wonder whether they will be able to attract more private-pay patients, which they feel they will need to remain financially viable. They see a need to become more efficient and market themselves to compete for patients. Reform could lead to consolidation as less competitive institutions fail to attract patients.

- Some safety net hospitals in New York are also concerned that they will see a reduction in Medicaid DSH funding, while at the same time continuing to see a disproportionate number of people who are ineligible for insurance—particularly undocumented immigrants (one speaker estimated that NYC has about 500,000)—or who are still unable to afford insurance after reform is implemented.
- Although reform was certainly on many presenters' minds, the more immediate effects of the poor economy also figured prominently in their concerns. The increase in the number of people eligible for public programs and the number of the uninsured has put additional pressure on safety net institutions. In addition, the state budget deficit is putting increased pressure on state lawmakers to look for savings in health care spending.

ENDNOTES

1. New York City, "Current Population Estimates," July 1, 2009; available at www.nyc.gov/html/dcp/html/census/popcur.shtml.

2. U.S. Census Bureau, "Annual Estimates of the Resident Population for Incorporated Places Over 100,000, Ranked by July 1, 2008, Population: April 1, 2000 to July 1, 2008 (SUB-EST2008-01)"; available at www.census.gov/popest/cities/SUB-EST2008.html.

3. New York City, "The Newest New Yorkers"; available at www.nyc.gov/html/dcp/html/census/nny_exec_sum.shtml.

4. Stephen Zuckerman, "Trends In Medicaid Physician Fees, 2003–2008," *Health Affairs,* 28, no. 3 (April 2009): pp. w510–w519.

5. Milliman Inc., "2010 Milliman Medical Index," May 2010; available at http://publications.milliman.com/periodicals/mmi/pdfs/milliman-medical-index-2010.pdf.

6. The New York City metropolitan statistical area (MSA) ranked 205th out of 232 MSAs on the U.S. Government Accountability Office's (GAO's) measure of the Federal Employee Health Benefit Program's preferred provider organization–adjusted health care spending per enrollee in 2001. See GAO, "Federal Employees Health Benefits Program: Competition and Other Factors Linked to Wide Variation in Health Care Prices," GAO-05-856, August 2005, p. 70; available at www.gao.gov/new.items/d05856.pdf.

MONDAY, APRIL 5, 2010

Afternoon — Arrival in New York City, and check in at headquarters hotel – The Park South Hotel [124 E 28th Street]

7:00 pm — Dinner (optional) – Les Halles [411 Park Avenue]

TUESDAY, APRIL 6, 2010

7:00 am — Breakfast available – Hotel restaurant

8:15 am — Walk or taxi to United Hospital Fund – Empire State Building [350 5th Avenue, 23rd Floor, Board Room]

9:00 am — Health Care in New York City: An Overview

James R. Tallon, Jr., *President*, United Hospital Fund

The **United Hospital Fund** is a nonprofit health services research and philanthropic organization whose mission is to shape positive change in health care for the people of New York. It undertakes research and policy analysis to improve the financing and delivery of care in hospitals, clinics, nursing homes, and other care settings. The Fund also makes grants to examine emerging issues and stimulate innovative programs.

- What are the demographic, ethnic, and health status characteristics of New York City's population?
- Who delivers care to the city's population, particularly those enrolled in Medicaid or without insurance? In what settings? What are the major sources of financing?
- What are the dynamics of the city's health care market? Who are the major players, and what alliances or enmities exist among them?
- Given the anomalies of this huge and diverse environment, what lessons does the city hold for other jurisdictions?

10:15 am — Health Information Technology (IT) in Support of Community Practice and Population Health

Amanda Parsons, MD, *Assistant Commissioner*, Primary Care Information Project, New York City Health Department

Barbara Caress, *Director of Strategic Policy and Planning*, The Building Service 32BJ Health Fund

Neil Calman, MD, *President and Chief Executive Officer*, Institute for Family Health

TUESDAY, APRIL 6, 2010 (CONTINUED)

10:15 am

Health IT in Support of Community Practice (continued)

The **Primary Care Information Project (PCIP)** of the New York City Department of Health and Mental Hygiene seeks to improve population health in disadvantaged communities through the use of health IT. Its long-term goal goes beyond adoption of electronic health records (EHRs) to a public health orientation that emphasizes prevention and clinical interventions with the greatest potential to save lives. PCIP operates with a budget of about $60 million in city, state, federal, and private funds. It recruits physician practices to participate and offers them a package of software and support services in exchange for specified investments and commitment.

The **Building Service 32BJ Health Fund** is sponsored by Local 32BJ of the Service Employees' International Union; it represents building service workers such as doormen. The Fund encourages its members to see physicians participating in PCIP.

The **Institute for Family Health (IFH)** operates 16 health centers in the Bronx, Manhattan, and two Hudson Valley counties; many were built and operate in collaboration with community-based organizations. The IFH provides clinical and psychosocial services to a "safety net" population, trains health professionals, and seeks to reduce disparities in care. It was the first free-standing primary care facility in New York to implement electronic health records throughout its network of practice.

- How is PCIP able to link health IT, quality, and public health?
- How does a practice become a PCIP participant? What are the advantages, from a health plan's perspective, of PCIP participation?
- How is electronically generated quality information used by various stakeholders, such as the city, physicians, health plans, consumers?
- What are the prospects for interoperability among the various EHR systems in use in the city?
- How can a primary care practice use health IT to gain leverage with specialists?
- How are patients being connected electronically to their providers and records?

TUESDAY, APRIL 6, 2010 (CONTINUED)

Noon	Break
12:15 pm	Taxi to Bellevue Hospital Center [426 1st Ave, 12th Floor, Rose Room]
12:45 pm	Lunch
1:15 pm	New York City Health and Hospitals Corporation: Serving All New Yorkers in an Era of Health Reform

Alan Aviles, JD, *President*, New York City Health and Hospitals Corporation

Lynda Curtis, *Senior Vice President/Executive Director*, Bellevue Hospital Center

Eric Manheimer, MD, *Medical Director*, Bellevue Hospital Center

Van Dunn, MD, *Chief Medical Officer*, MetroPlus Health Plan

Ramanathan Raju, MD, *Executive Vice President/Chief Medical Officer*, New York City Health and Hospitals Corporation

LaRay Brown, *Senior Vice President*, Corporate Planning, Community Health and Intergovernmental Relations, New York City Health and Hospitals Corporation

The **New York City Health and Hospitals Corporation (HHC)**, the largest municipal hospital and health care system in the United States, is a $6.3 billion public benefit corporation. HHC serves 1.3 million New Yorkers every year, 450,000 of them uninsured. HHC provides medical, mental health, and substance abuse services through its 11 acute care hospitals, four skilled nursing facilities, six large diagnostic and treatment centers, more than 80 community-based clinics, and a home health agency. HHC contracts with only 2 of the city's 14 Medicaid managed care plans: its wholly owned subsidiary MetroPlus and another hospital-sponsored plan in which it also has an ownership stake, HealthFirst.

- What enables HHC to function as an integrated delivery system for New York City's low-income population? How does its structure support its mission?
- What mechanisms are in place to identify opportunities for improvement within the system? How are best practices developed and disseminated across facilities?

TUESDAY, APRIL 6, 2010 (CONTINUED)

1:15 pm — New York City HHC (continued)

- How does HHC's relationship with the health plan MetroPlus facilitate the creation of incentives for quality improvement?
- How has HHC been able to leverage health IT in support of patient safety and chronic disease management?
- What is HHC's contractual relationship with the medical schools whose doctors staff its hospitals?
- How does HHC address the cultural competency challenges posed by the population it serves?
- What is the likely impact on HHC of federal health reform legislation?

3:15 pm — Subway or taxi to Charles B. Wang Community Health Center [168 Centre Street, 3rd Floor]

3:45 pm — The Charles B. Wang Community Health Center: Health Care in the Neighborhood

Jane T. Eng, JD, *Chief Executive Officer, Charles B. Wang Community Health Center*

Lynn Sherman, *Chief Financial Officer, Charles B. Wang Community Health Center*

Perry Pong, MD, *Chief Medical Officer, Charles B. Wang Community Health Center*

The **Charles B. Wang Community Health Center (CBWCHC)** describes itself as a medical home for underserved Asian Americans. It offers services in internal medicine, women's health, pediatrics, dental care, mental health, and pharmacy, along with care management, social work assistance, nutritional counseling, and health education. Community outreach and health promotion are important elements of serving CBWCHC's constituency.

- What were CBWCHC's principal objectives in adopting health IT? What have been the challenges of integrating it into health center workflows? Has it measurably improved care delivery?
- What quality data are regularly collected? How and by whom are they used? Who sets quality improvement goals? How are quality measures selected?

TUESDAY, APRIL 6, 2010 (CONTINUED)

3:45 pm — **The Charles B. Wang Community Health Center: Health Care in the Neighborhood** (continued)

- How does adding care coordination to a clinical mission affect staffing patterns?
- How is workforce development factored into community outreach and education?

5:30 pm — **Optional Health Center tour**

7:00 pm — **Dinner – Dolcino**
[517 Second Avenue, between 28th and 29th Streets]

WEDNESDAY, APRIL 7, 2010

7:00 am — **Breakfast available – Hotel restaurant**

7:45 am — **Walk or taxi to United Hospital Fund**

8:30 am — **Medicaid as a Force for Improving Service Delivery**

Michael Birnbaum, *Director of Policy*, Medicaid Institute, United Hospital Fund

Michael Sparer, PhD, JD, *Professor and Department Chair of Health Policy and Management*, Mailman School of Public Health, Columbia University

Patricia Wang, JD, *President and Chief Executive Officer*, HealthFirst

New York state has the costliest Medicaid program in the nation. More than 4 million low-income families and low-income elderly and disabled individuals, including more than 2 million residents of New York City, are enrolled in the program. For those enrolled, Medicaid provides payment for covered services, including acute care, preventive services, and long-term care. It also provides crucial supplemental funds in the form of disproportionate share hospital (DSH) payments to hospitals to compensate them for Medicaid shortfalls and uncompensated care costs.

Managed care is mandatory for most Medicaid enrollees in New York City. The city's Medicaid managed care market currently has 14 competing health plans, many of which grew out of hospital systems or organizations. Three of the four largest plans (HealthFirst, HealthPlus, and MetroPlus) are hospital-sponsored prepaid health service plans. In New York City's hospital-dominated market,

WEDNESDAY, APRIL 7, 2010 (CONTINUED)

8:30 am — **Medicaid as a Force for Improving Service Delivery** (continued)

the proliferation of plans with overlapping networks, competing demands of other payers, and the lack of provider risk sharing may mitigate the leverage that any individual plan can have over providers. On the other hand, a plan's affiliation with hospitals also provides some potential for coordination.

- What populations does Medicaid cover? What services are covered? What populations account for most Medicaid spending?
- Do the state and the enrollees get sufficient value for New York's relatively high Medicaid spending per enrollee?
- What is the role of Medicaid managed care plans in New York City? How much leverage do they have over hospitals and other providers to implement quality improvement measures?
- Currently, certain services (for example, pharmacy and behavioral health care) are carved out of the Medicaid managed care benefit, and certain populations (such as long-term care facility residents and those with serious and persistent mental illness) are not in managed care plans. How do these policies affect quality and cost?
- In what ways have EHRs changed plans' ability to manage and coordinate care?
- What can be done to improve case management and care coordination, or to reduce avoidable readmissions for Medicaid enrollees, particularly those in managed care plans? What are the levers to make these changes? What are the barriers?

10:00 am — **Place Matters: Community-Oriented Health Interventions**

Kathleen Klink, MD, *Director*, Columbia University Center for Family and Community Medicine (New York-Presbyterian Hospital's Washington Heights Initiative)

Danielle C. Ompad, PhD, *Associate Director*, Center for Urban Epidemiologic Studies (CUES), New York Academy of Medicine

Keosha T. Bond, *Project Director*, CUES, New York Academy of Medicine

This session will provide insights into two organizations' approaches to improving the health of communities.

WEDNESDAY, APRIL 7, 2010 (CONTINUED)

10:00 am — Place Matters: Community-Oriented Health Interventions (continued)

New York-Presbyterian is the largest hospital in New York City and a prestigious academic medical center affiliated with two medical schools. Development of its Washington Heights Initiative began in May 2009 with the goal of improving the health of the Washington Heights community through an array of programs, including the development of a patient-centered medical home. Internal workgroups have developed a highly structured process to develop programs and metrics for assessing progress.

The **New York Academy of Medicine's Center for Urban Epidemiologic Studies (CUES)** is funded by corporate, nonprofit, and government sources. It focuses on East Harlem and, more broadly, New York City residents. CUES has undertaken research and evaluation on a number of different areas, including HIV and other infectious diseases, mental health and substance abuse, immunizations, violence, asthma, nontraditional public health provider models, the health of the elderly New York City residents, and disaster response.

- Why is a neighborhood a relevant locus for health interventions?
- What motivates an organization to develop initiatives to improve the health of a community?
- How do these organizations identify issues to focus on and metrics to assess progress?
- What are the organizational challenges to developing and operating initiatives to serve low-income communities?
- How can communities be engaged, including community members and community physicians, so that their opinions are factored into intervention plans?
- Is it possible to create and sustain institutional support for programs that do not generate revenue?
- What funding is available for community health programs?

11:15 am — Break

11:30 am — Shuttle departure – Montefiore Medical Center [Centennial Building, 3332 Rochambeau Avenue, 4th Floor, President's Conference Room]

WEDNESDAY, APRIL 7, 2010 (CONTINUED)

12:30 pm — Lunch

1:00 pm — Montefiore Medical Center: Beacon in the Bronx

Donald L. Ashkenase, *Special Advisor to the President*

Gary Kalkut, MD, *Senior Vice President and Chief Medical Officer*

Joel A. Perlman, *Executive Vice President and Chief Financial Officer*

Stephen Rosenthal, *Corporate Vice President*, Network Care Management, Montefiore's Integrated Delivery System

Steven M. Safyer, MD, *President and Chief Executive Officer*

Located in the Bronx, **Montefiore Medical Center (MMC)** is an integrated delivery system and one of the largest health care systems in the nation. MMC draws 90 percent of its patients from the Bronx and Westchester. The population that MMC serves in the Bronx has a significant disease burden and the highest rate of uninsured adults in the New York Metropolitan area. In 2008, MMC's three general hospitals and children's hospital had a combined 1,491 beds and 81,952 discharges. In that same year, the system provided about 2 million ambulatory care visits in its 23 primary care centers, 16 school health centers, four emergency departments, and other ambulatory care settings. MMC is also an academic medical center affiliated with the Albert Einstein College of Medicine of Yeshiva University. MMC has partnered with a coalition of payers and other providers in the Bronx in the "Bronx Collaborative" to improve outcomes and reduce costs through financial incentives and more cost-effective care delivery.

- How does community need shape MMC's mission and priorities?
- How does MMC's structure (array of facilities, relationships with providers) support its mission and goals?
- What is MMC's payer mix? How do payer mix and payment incentives from various payers shape the delivery of care and institutional priorities?
- What is the Bronx Collaborative, how is it funded, and what does it hope to accomplish? What methods can be used to measure the success of the Collaborative? Why did MMC choose to participate in the Collaborative?

WEDNESDAY, APRIL 7, 2010 (CONTINUED)

1:00 pm — **Montefiore Medical Center: Beacon in the Bronx** (continued)

- What is MMC's health IT strategic plan? How does IT support clinical practice, quality improvement, and population health management? What does MMC hope to achieve by applying for a Beacon Community grant from the Office of the National Coordinator for Health IT? What initiatives are in progress to connect patients electronically?
- How does MMC manage the continuum of patients from those needing preventive and primary care to the most complex?

3:00 pm — **Bus to Park South Hotel**

4:00 pm (or later) — **Walk or taxi to Penn Station**

6:00 pm — **Train Departure to Washington, DC**

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BIOGRAPHICAL SKETCHES

FEDERAL PARTICIPANTS

Melissa Bartlett, JD, is counsel for the Republican staff of the U.S. House of Representatives Committee on Energy and Commerce. Prior to working for the committee, she was a HIPAA privacy program specialist for the U.S. Department of Health and Human Services Office for Civil Rights (OCR). Before joining OCR, Ms. Bartlett was the director of private market regulation for America's Health Insurance Plans. Ms. Bartlett was also legislative counsel for the American Medical Group Association, where she focused on federal regulatory and legislative issues of integrated health care systems and multispecialty medical group practices. Ms. Bartlett is a graduate of the University of Kentucky College of Law and a member of the Kentucky Bar Association.

Andrew Bindman, MD, is a 2009–2010 Robert Wood Johnson Health Policy Fellow working with the U.S. House of Representatives Committee on Energy and Commerce. He is a professor of medicine, health policy, epidemiology, and biostatistics at the University of California San Francisco (UCSF). He is director of the California Medicaid Research Institute, chief of the Division of General Internal Medicine at UCSF's affiliated San Francisco General Hospital, and director of UCSF's Primary Care Research Fellowship. He has practiced and taught primary care at San Francisco General Hospital and its affiliated clinics for the past 20 years. In his work, Dr. Bindman has established the association between poor access to care and preventable hospitalizations for ambulatory care sensitive conditions. He has used this measure to evaluate Medicaid programs and to design interventions to improve quality of care for low-income patients with chronic disease. He has won numerous awards for his work, including AcademyHealth's Young Investigator Award and the Paper of the Year Award.

Stephen Cha, MD, is a board-certified internist and addresses a range of health care issues as professional staff (D) for the U.S. House of Representatives Committee on Energy and Commerce. He earned his medical degree from Brown University and completed his internal medicine residency at the Montefiore Medical Center in New York City, where he also served as chief resident. Dr. Cha received a degree in health sciences research as part of the Robert Wood Johnson Clinical Scholars Program at Yale University.

Kim Corbin, JD, is legislative counsel to Rep. Jerrold Nadler (D-NY), handling a wide range of issues, including health care and tax issues. Before joining Rep. Nadler's office, Ms. Corbin was policy director for the Scott Kleeb for Senate Campaign in Omaha, Nebraska; senior legislative aide at NARAL Pro-Choice America in Washington, DC; and an associate at Debevoise & Plimpton, LLP, in New York City.

Gustavo D. Cruz, DMD, is a Robert Wood Johnson Health Policy Fellow and adjunct associate professor of epidemiology and health promotion at New York University College of Dentistry. From 1997 to 2001, Dr. Cruz was associate director of the National Institutes of Health (NIH)–funded Northeast Research Center for Minority Oral Health, where he was also the principal investigator of one of the projects within the Center. Dr. Cruz was a member of a panel of experts that developed the first U.S. guidelines, "Oral Health Care during Pregnancy and Early Childhood." Dr. Cruz received his DMD degree from the University of Puerto Rico and his MPH degree from Columbia University School of Public Health. He was the recipient of a National Research Fellowship Award during which he also completed a residency in oral public health at Columbia University College of Dental Medicine and the New York City Department of Health. He is a diplomate of the American Board of Dental Public Health.

Barbara Dailey is the director of the Division of Quality, Evaluation and Health Outcomes within the Centers for Medicare & Medicaid Services (CMS). She is responsible for leading quality improvement efforts for Medicaid and Children's Health Insurance Programs (CHIP). In this capacity, she supports state efforts to demonstrate the impact of these programs aimed at achieving safe, effective, efficient, patient-centered, timely, and equitable care. Ms. Dailey is leading the nation's first National Medicaid Quality Framework initiative in collaboration with state Medicaid programs and, in 2010, CHIP programs. She also leads CMS efforts in collaboration with other federal agencies to implement Title IV of the Children's Health Insurance Program Reauthorization Act of 2009 to improve the quality of health care for children. Before joining CMS, Ms. Dailey was a quality manager with Schaller Anderson, a national Medicaid health care consulting firm, and was senior regional quality advisor for CIGNA HealthCare. She has coordinated strategic planning for the Johns Hopkins School of Public Health and was the research project coordinator for the nation's first childhood cancer screening project. Ms. Dailey is a certified professional in health care quality and earned her master of science degree

in nursing management from Johns Hopkins University. Her clinical experience includes pediatric oncology and neonatal intensive care.

Ruth Ernst, JD, is an assistant counsel in the U.S. Senate Office of the Legislative Counsel. She has been with that office for over 16 years. She has primary responsibility for drafting legislation relating to health care, the uninsured, and entitlement programs, including Medicaid and the Children's Health Insurance Program (CHIP), foster care, welfare, child support, and social security. Legislation Ms. Ernst has worked on includes the Personal Responsibility and Work Opportunity Reconciliation Act of 1996; the Medicaid and CHIP provisions in the Balanced Budget Act of 1997; the low-income subsidies and Medicaid provisions in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003; and, most recently, the Children's Health Insurance Program Reauthorization Act of 2009; the Medicaid and welfare provisions in the American Recovery and Reinvestment Act of 2009; and the Medicaid, CHIP, and CLASS Act provisions in the Senate's health care reform bills for the 111th Congress. She has a JD degree from the University of Chicago and an AB degree from Mount Holyoke College.

Rachel Post Fenton serves as the legislative director for her hometown congressman, Rep. Vernon J. Ehlers (R-MI). She has been part of his legislative team since 2003 and provides advice on health, education, labor and other social policy issues. Ms. Fenton began her time on Capitol Hill during graduate school, when she served as an intern for Sen. Michael Enzi (R-WY). Previously, she conducted health policy research at a rehabilitation hospital and the Social Security Administration. She also worked in the administrative office of a nursing home and as a college admissions representative. Ms. Fenton received a master's degree in public policy from Georgetown University and her undergraduate degree from Calvin College.

Emily Gibbons is the legislative director for Rep. Eliot Engel (D-NY). Her primary focus is assisting Rep. Engel on health care issues for the U.S. House of Representatives Committee on Energy and Commerce and global health for the Committee on Foreign Affairs. Originally from Massachusetts, she moved to Washington, DC, after completing her bachelor's degree in sociology at Vassar College. She has worked for four different members of Congress as well as at the White House under former President Clinton. Ms. Gibbons also earned a master's degree in public policy with a concentration in health policy from the George Washington 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.

Jim Hahn, PhD, is a health economist with the Congressional Research Service, where he conducts research and policy analyses on issues related to health care payment reform, Medicare physician payment, comparative effectiveness, and geographic variation in health care. He serves as an expert resource for the Congress as it develops legislation on these and related issues. He has published articles in the *New England Journal of Medicine* and other peer-reviewed publications on the effect of public, nonprofit, and for-profit ownership status and system affiliation on the economic performance of hospitals and on a comparative analysis of physician expenditures in the United States and Canada. He previously held positions with the Government Accountability Office and with Lewin and Associates, and has held faculty appointments with the University of North Carolina at Chapel Hill and with Trinity University. He is a graduate of Stanford University.

Suzanne Hassett is a policy coordinator in the Office of the Secretary in the Department of Health and Human Services (DHHS), responsible for coordinating policy information regarding the Medicaid program and the Children's Health Insurance Program (CHIP), as well as the office on disability. Before coming to the Secretary's office nine years ago, she worked in the office of the administrator of the Health Care Financing Administration (now CMS), primarily on Medicaid and CHIP issues. Before joining DHHS, Ms. Hassett worked for Sen. Jack Reed (D-RI) for five years. She has a bachelor of arts degree in political science from Trinity College in Washington, DC.

David Keller, MD, is currently serving as a Robert Wood Johnson Health Policy Fellow in the Office of the Assistant Secretary for Planning and Evaluation at the Department of Health and Human Services. He is clinical associate professor of pediatrics at the University of Massachusetts Medical School. Dr. Keller served for many years as medical director of South County Pediatrics, a community-based teaching practice located in Webster, Massachusetts. He was also the pediatric director of the Community Faculty Development Center, a collaborative faculty development program for community preceptors, and medical director of Family Advocates of Central Massachusetts, a medical-legal partnership for children in Worcester County. His work in medical-legal partnership, faculty development, and advocacy training has been presented at national and international meetings and published in peer-reviewed journals. Dr. Keller recently completed a physician advocacy fellowship by the Center for Medicine as a Profession to support his collaboration with Health Law Advocates, a statewide advocacy organization working to improve access to mental health care in Massachusetts.

Eli Kogan is the senior legislative assistant in the Office of Rep. Joseph Crowley (D-NY), serving as Mr. Crowley's primary advisor on health care matters before the U.S. House of Representatives Committee on Ways and Means. In addition to his role as health care advisor, Mr. Kogan works in conjunction with the New Democrat Coalition (NDC) executive director on health care matters important to NDC members and staff. He attended the University of Maryland at College Park, where he earned his bachelor's degree in political science with a minor in history.

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

Susan Lumsden is the director for the Division of State and Community Assistance, within the Health Resources and Services Administration's (HRSA's) Office of Health Information Technology (OHIT). She joined OHIT, whose mission is to promote the adoption of health IT as a tool to improve the quality of care for medically underserved populations, in May of 2006. A majority of Ms. Lumsden's clinical practice (eight years) was with the National Institutes of Health.

Thereafter, she spent six years in the area of federal occupational health as a nurse consultant, then as a fiscal manager. She worked for two years as a nurse consultant with the Center for School-Based Health as part of HRSA's Program for Special Populations. From there, she spent seven years as a senior public health analyst and then branch chief working with HRSA's State Primary Care Associations, National Technical Assistance Organizations, and Health Center Network and health system grantees.

Kate Massey is the unit chief of the Low-Income Health Programs and Prescription Drugs Cost Estimates Unit at the Congressional Budget Office (CBO). She oversees the process by which CBO provides estimates of legislation in response to congressional requests related to Medicaid, the Children's Health Insurance Program (CHIP), prescription drug policy, and Public Health Service agencies. Most recently, she has been involved in CBO's efforts to estimate the cost and coverage effects of the comprehensive health legislation currently under congressional consideration. Before joining CBO, Ms. Massey worked at the Office of Management and Budget (OMB). While there, her responsibilities included assisting in the formulation of the President's legislative and regulatory agenda. She worked on a number of health policy issues while at OMB, including 1115 waiver policy, Medicaid reform, program integrity, private market health insurance initiatives, and Medicaid spending trends. Ms. Massey received a bachelor of arts degree from Bard College and a master of public affairs degree from the Lyndon B. Johnson School of Public Affairs, University of Texas.

Anne Mutti is a principal policy analyst at the Medicare Payment Advisory Commission (MedPAC), focusing most recently on Medicare payment policy changes to improve quality and efficiency. Before joining MedPAC in 1999, Ms. Mutti was a senior analyst for the National Bipartisan Commission on the Future of Medicare. Previously, she worked as a Medicare program examiner for the Office of Management and Budget. She has also worked at the American Association of Health Plans, at the Greater New York Hospital Association, and for the late Sen. Daniel P. Moynihan. Ms. Mutti received her bachelor of arts degree from the State University of New York, Albany, and her master's degree in public administration from New York University.

Kirstin Nelson is an analyst with the Congressional Budget Office (CBO). She works primarily on Medicaid and the Federal Employees Health Benefits program. Before joining CBO, she worked for

the Wisconsin Medicaid program. Ms. Nelson holds a master of international public affairs degree from the University of Wisconsin Madison.

Allison Orris, JD, is the director of the Low-Income Programs Analysis Group in the Office of Legislation at the Centers for Medicare & Medicaid Services (CMS). She directs a team of legislative analysts who provide technical, analytical, advisory, and information services to Hill staff, other parts of the Department of Health and Human Services, the White House, private organizations, and the general public on Medicaid, the Children's Health Insurance Program, and programs impacting the uninsured. Prior to joining CMS, Ms. Orris was a senior legislative associate at the Center on Budget and Policy Priorities. There she worked with the center's policy analysts to communicate its analyses to policymakers and legislative staff and also worked extensively with state and national advocacy organizations on a range of health policy issues. Earlier in her career, she practiced health care law, focusing primarily on financing issues related to safety net hospitals and health systems. Before law school, Ms. Orris worked in the Office of the Assistant Secretary for Planning and Evaluation at the Department of Health and Human Services, where she focused on issues related to racial and ethnic health disparities. She earned a law degree from Yale Law School and a BA degree in history from Columbia University.

Josh A. Phillips has worked for the Centers for Medicare & Medicaid Services (CMS) Office of Legislation, Congressional Affairs Group in Washington, DC, for eight years as the congressional liaison for four CMS regions. He is currently the congressional liaison to Region I (Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island) and Region II (New York, New Jersey, U.S. Virgin Islands, and Puerto Rico).

John Richardson is a principal policy analyst at the Medicare Payment Advisory Commission (MedPAC), where he focuses on quality measurement, pay-for-performance, health information technology, delivery system reform, and disparities. Before joining MedPAC, Mr. Richardson was a vice president at Avalere Health, a Washington strategic advisory and consulting firm. Previously, he was director of program development at CalOptima, a Medicaid managed care organization in Orange County, California. He also worked as a program examiner in the Health Financing Branch of the Office of Management and Budget, focusing on physician payment, beneficiary cost

sharing, and Medicare budget issues. He has an MPP degree from Duke University and an AB degree from Harvard University.

Richard V. Rimkunas is the section research manager of the Health Insurance and Financing Section of the Domestic Social Policy Division of the Congressional Research Service (CRS), where he directs a group of analysts who provide quantitatively and qualitatively based legislative support for health issues surrounding Medicare, Medicaid, and private health insurance. While at CRS, he has also served as analyst and later as specialist in social legislation. His research interests include the study of health insurance coverage and access to health providers for low-income and the working poor populations. Mr. Rimkunas has served as an instructor at the University of Maryland and at the University of Baltimore. He was elected to the National Academy of Social Insurance in 2002. Mr. Rimkunas received his MA degree in government and politics from the University of Maryland.

Andy Schneider, JD, is chief health counsel of the U.S. House of Representatives Committee on Energy and Commerce, chaired by Congressman 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.

Mark D. Schwartz, MD, FACP, is a 2009–2010 Robert Wood Johnson Health Policy Fellow. He is associate professor of medicine at New York University (NYU) School of Medicine. After studying medicine at Cornell University and training in internal medicine at NYU, Dr. Schwartz was awarded a Bowen-Brooks Fellowship by the New York Academy of Medicine to study medical education innovation in Israel and Holland, and then completed a general internal medicine fellowship at Duke University. At NYU he was selected as a Robert

Wood Johnson generalist physician faculty scholar. He has been a primary care physician in urban underserved settings for 20 years.

Since 1995, Dr. Schwartz has led NYU's General Internal Medicine Fellowship Program and established its Masters of Science in Medical Education program. He directs NYU's NIH Clinical Research Training Program and leads its Masters of Science in Clinical Investigation program. He also directs the Fellowship in Medicine and Public Health Research. Dr. Schwartz leads a Veterans Administration study of how educational interventions for health professionals improve patient outcomes. NYU recently named him director of translational research education and careers in its Clinical Translational Science Institute. The Association of Clinical Research Training awarded him its distinguished research educator award in 2008.

Aarti Shah, JD, currently serves as health counsel for the Republican staff with the U.S. House of Representatives Committee on Energy and Commerce. She joined the committee after working for seven years on the staff of Rep. Joe Barton (R-TX), where she held the position of senior legislative assistant, focusing primarily on health care issues. Ms. Shah is a native of Houston, Texas. She holds a JD degree from Catholic University, a master's degree in health care administration from Texas Woman's University, and a BS degree in biology from the University of Houston.

BIOGRAPHICAL SKETCHES

SPEAKERS

Donald L. Ashkenase assumed the role of special advisor to the president responsible for governmental relations and malpractice at Montefiore Medical Center in January 2010. Prior to that he served as executive vice president, corporate, of Montefiore Medical Center from 1987 to 2009. He also served as the chief financial officer at Long Island Jewish Medical Center and spent nine years at the New York City Health and Hospitals Corporation, leaving as first vice president of finance and chief financial officer. Mr. Ashkenase graduated in 1965 from Brooklyn College and served four years in the United States Air Force as a hospital administrator. He received a master's degree from Wagner College. Mr. Ashkenase is adjunct assistant professor at Columbia University, School of Public Health. He is chairman of the board of HealthFirst and Chairman of the Board of the Bronx Regional Health Information Organization.

Alan D. Aviles, JD, is president and chief executive officer of the New York City Health and Hospitals Corporation (HHC), the largest municipal health care system in the nation. He was appointed by New York City Mayor Michael R. Bloomberg in February 2005 to lead the 39,000 employees of this $6 billion corporation. Mr. Aviles' experience in public service dates back to the late 1970s. Before entering the health care field, Mr. Aviles spent his career fighting for social justice as a lawyer and assistant attorney general. His longstanding involvement in civil rights litigation includes a groundbreaking 1982 lawsuit that challenged discrimination against HIV/AIDS patients, and later litigation that led the U.S. Supreme Court to compel a major skilled trade apprenticeship program to open its doors to qualified minority candidates for the first time. During the past 12 years he has served in several leadership roles within HHC. Before his appointment as president/chief executive officer, Mr. Aviles served as HHC's general counsel. He also previously led one of HHC's seven regional health care networks. Mr. Aviles serves on the boards of a number of organizations, including the Greater New York Hospital Association, the Healthcare Association of New York State, the Primary Care Development Corporation, and Public Health Solutions (formerly MHRA).

Michael Birnbaum is director of policy for the Medicaid Institute at United Hospital Fund, which provides information and analysis on New York's Medicaid program. He supervises the work of Fund

staff and oversees the analyses and reports produced for the Institute by research partners and consultants. Prior to joining the Fund, Mr. Birnbaum served as an analyst in the Congressional Budget Office (CBO), where his unit forecast baseline Medicare and Medicaid spending and estimated the fiscal impact of federal health legislation. He authored and co-authored CBO cost estimates on Medicare reform proposals in the Balanced Budget Refinement Act of 1999 and in the President's Budgets of 1999 and 2000, and contributed to the construction of original CBO estimation models. Previously, Mr. Birnbaum was an associate at AcademyHealth. He is adjunct assistant professor of health policy and management at Columbia University's Mailman School of Public Health, and adjunct associate professor of public administration at New York University's Wagner School of Public Service. Mr. Birnbaum holds an MPhil degree in economics from Cambridge University and an MSc degree, with distinction, in public administration and public policy from the London School of Economics. He is a graduate of Wesleyan University.

Keosha T. Bond is a project director in the Center for Urban Epidemiologic Studies (CUES). Ms. Bond currently works on projects that focus on asthma management among children living in low-income, underserved communities in New York City. She is also involved in projects related to HIV risk reduction among African Americans living in New York City. Ms. Bond has several years of experience working on community health projects that focus on eliminating health disparities related to perinatal issues in urban communities. She has also worked closely with the female incarcerated population to examine parent-child interaction, parenting competency, child development, and recidivism. Ms. Bond holds a BS degree in psychology from Fordham University and a MPH degree in community health education from Hunter College, Schools of the Health Professions, at the City University of New York. Ms. Bond's research interests are in health disparities and social determinants of health.

LaRay Brown is the senior vice president for Corporate Planning, Community Health and Intergovernmental Relations at the New York City Health and Hospitals Corporation (HHC), the largest municipal public hospital system in the country. Ms. Brown and her staff provide leadership and analytical support to the system-wide strategic planning efforts of HHC, coordinate the system's policy and program development for special populations, and serve as liaison to various branches of government, as well as state and city agencies. She is also responsible

for the development and execution of the HHC's legislative initiatives. In addition, Ms. Brown is the senior HHC executive responsible for the implementation of a multiyear effort to transform the operations of the public hospitals' ambulatory care clinics. Ms. Brown has held several positions within HHC during her 21-year tenure, including serving as the vice president of Mental Health and Chemical Dependency Services. Prior to joining HHC, she served as the deputy director for Program Operations at the New Jersey Division of Youth and Family Services. Ms. Brown graduated summa cum laude from the University of Pennsylvania and received her graduate training at the University of Pennsylvania FELS Center for Government Policy.

Neil Calman, MD, is a board-certified family physician who has practiced in the Bronx and Manhattan for the past 30 years. He is president as well as a co-founder of the Institute for Family Health. Since 1983, Dr. Calman has led the Institute in developing family health centers in the Bronx and Manhattan, and recently in acquiring a network of community health centers in the Hudson Valley. He leads the Institute in a variety of cutting-edge programs; for example, in 2002, the Institute became one of the first community health center networks in the country to implement a fully integrated electronic medical record and practice management system. In recognition, Dr. Calman received the 2006 Physician's Information Technology Leadership Award, presented annually by the Healthcare Information and Management Systems Society. Dr. Calman serves on a variety of committees, including the National Coordinator for Health Information Technology's HIT Policy Committee and the executive committee of New York City's Primary Care Health Information Consortium. For his work in public health, Dr. Calman has received three national awards: the Robert Wood Johnson Foundation's Community Health Leadership Award, the American Academy of Family Physicians' Public Health Award, and the Pew Charitable Trusts' Primary Care Achievement Award.

Barbara Caress has over 25 years of experience as a nonprofit and public agency manager, consultant, and administrator. She is currently director of strategic policy and planning for the Local 32BJ Health, Pension, Legal and Training Funds, which provide benefits to 200,000 people living in seven states. She spent many years as a health care consultant working for such clients as the New York City and State Health Departments, the Community Service Society, and Local 119. Author of a wide range of health policy reports

and reviews, Ms. Caress received her undergraduate and graduate education at the University of Chicago.

Lynda Curtis is the senior vice president and executive director of the South Manhattan Health Care Network/Bellevue Medical Center. She administers a network of three nationally renowned institutions: Bellevue (America's oldest public hospital), Coler-Goldwater, and Gouverneur. Combined, the network operates 3,133 beds, a diagnostic and treatment center; and five community-based treatment centers. Ms. Curtis joined the municipal hospital system (NYC Health and Hospitals Corporation [HHC]) as a senior children's counselor at the Sydenham Neighborhood Family Care Center in Harlem in 1974. She quickly advanced through the administrative ranks, eventually becoming acting deputy executive director at Harlem Hospital before assuming key corporate-wide assignments in the areas of operations, facilities management, and quality management. In 1993, she served as corporate vice president for Quality Management Services, responsible for implementing HHC's Total Quality Management Initiative. From there, Ms. Curtis assumed key facility leadership positions. In 2001, Ms. Curtis became network senior vice president/executive director of the North Brooklyn Health Network (NBHN)/Woodhull Medical Center where she steered NBHN through a fundamental change in its performance improvement process. Ms. Curtis graduated from the State University of New York at Buffalo with a degree in childhood education, and earned her master's degree in special education from Fordham University.

Van Dunn, MD, is chief medical officer of MetroPlus Health Plan, a subsidiary of the New York City Health and Hospitals Corporation (HHC). MetroPlus provides access to health care services to over 386,000 New York City residents in Brooklyn, Queens, the Bronx, and Manhattan. Dr. Dunn is a primary care physician. Throughout his career he has held clinical and administrative positions at the state, federal, and local levels, where he has worked to ensure access to quality health care services for all regardless of ability to pay. Early in his career, he served as medical director of a community health center in Boston; director of community health programs for Boston Health and Hospitals; deputy commissioner of the Massachusetts Department of Public Health; and senior health policy advisor to the late Sen. Edward M. Kennedy. For ten years, Dr. Dunn served as senior vice president and chief medical officer of HHC, the largest public hospital system in the country. Dr. Dunn received his BS degree from the Massachusetts

Institute of Technology, MD degree from Cornell University Medical College, and MPH degree from the Harvard School of Public Health. He completed an internal medicine residency and chief residency at Boston City Hospital. In addition, he completed a National Library of Medicine Fellowship in Clinical Decision Making and Computer Sciences at the New England Medical Center. He is an assistant professor of public health at Weill Medical College of Cornell University.

Jane T. Eng, JD, is the chief executive officer of the Charles B. Wang Community Health Center (CBWCHC). Ms. Eng has been associated with CBWCHC for more than 30 years. Under her leadership, the health center expanded its service capacity by adding additional clinical sites in Manhattan and Flushing to meet the growing needs of the rapidly expanding Asian American population in the New York metropolitan area. Ms. Eng is a graduate of Columbia University and Harvard Law School and has served as an administrative law judge for the City of New York, Department of Finance. She is a member of the Board of Directors of New York's primary care association, the Community Health Care Association of New York State, and has served on the Executive Committee of the Association of Asian Pacific Community Health Organizations for the past ten years.

Gary Kalkut, MD, has been senior vice president and chief medical officer at Montefiore Medical Center since 2003. He is also serves as associate professor of clinical medicine, attending physician, and the vice president and medical director. From 2001 to 2002 he was chief, medical service, in the Moses Division of the Department of Medicine at Montefiore Medical Center. From 1996 to 2001, he was medical director of the AIDS Center at and attending physician in the Division of Infectious Diseases at Montefiore Medical Center and associate professor of clinical medicine at the Albert Einstein College of Medicine. He was the director of the Special Care (AIDS) Clinic at North Central Bronx Hospital from 1991 to 1996. He has a MD degree from Boston University School of Medicine, an MPH degree from Columbia University, and a BS degree from Vassar College.

Kathleen Klink, MD, is the director of the Columbia University Center for Family and Community Medicine and chief of service for Family Medicine at New York-Presbyterian Hospital. She recently led the expansion of the center to enhance the research and development missions of Family and Community Medicine. She co-chairs the patient-centered medical home committee of the Washington Heights Initiative, a Columbia University Medical Center effort to measurably

improve the health of the northern Manhattan region of New York City, a largely immigrant, Spanish-speaking community. Dr. Klink completed service in the office of former Sen. Hillary Rodham Clinton as a Robert Wood Johnson Health Policy Fellow in December 2008. She began her professional medical career at Coney Island Community Health Center. In 1996 she became a founding faculty member of the family medicine program at (then) Presbyterian Hospital, where she remains as director. Dr. Klink received her MD degree from the University of Miami in 1985 and completed her residency training at Jackson Memorial Hospital in family medicine in 1988.

Eric Manheimer, MD, is a general internist and geriatrician who also serves as the medical director and patient safety officer at Bellevue Hospital and the South Manhattan Network of the New York City Health and Hospitals Corporation. He is a clinical professor of medicine at the New York University School of Medicine. His major areas of focus have been re-engineering clinical service lines, patient safety initiatives, revenue cycle improvement, clinical program development, and minority health initiatives. Dr. Manheimer was previously chief of general internal medicine at Dartmouth Hitchcock Medical Center. At Dartmouth he had multiple roles as a clinician, teacher, and researcher in the psychosocial aspects of cardiovascular surgery and mood disorders in the general medical population. Dr. Manheimer is a graduate of Downstate School of Medicine and the Kings County Hospital internal medicine training program. He has worked internationally in Haiti, Pakistan, and throughout Latin America. He serves on the board of the International Rescue Committee.

Danielle C. Ompad, PhD, is the associate director of the Center for Urban Epidemiologic Studies (CUES) at the New York Academy of Medicine. Dr. Ompad is also an adjunct assistant professor in the Department of Nutrition, Food Studies and Public Health at New York University's Steinhardt School of Culture, Education, and Human Development. Dr. Ompad has extensive experience in design, conduct and analysis of community-based studies focusing on illicit substance use, risky sexual behavior, and access to vaccines in urban populations. At CUES, she is primarily responsible for the supervision of the research storefront and roving recruitment vehicle. She has several studies related to urban health that are funded by the U.S. National Institute on Drug Abuse. She is currently supervising the IMPACT Studies which are investigating the relationship between HIV risk, substance use, mental health, and the neighborhood

physical and social environments in 38 economically disadvantaged neighborhoods in New York City. Dr. Ompad completed a BS degree in biology at Bowie State University and an MHS degree and a PhD degree in infectious disease epidemiology at the Johns Hopkins University School of Public Health.

Amanda Parsons, MD, is assistant commissioner of the New York City Department of Health and Mental Hygiene (DOHMH), overseeing all of the activities of the Primary Care Information Project (PCIP). Previously, Dr. Parsons was the director of medical quality and was responsible for creating and leading the quality improvement, billing consulting and electronic medical record (EMR) consulting teams deployed to PCIP's small physician practices. Prior to joining PCIP in 2008, Dr. Parsons spent four years at McKinsey & Company, ultimately as an engagement manager serving clients in the pharmaceutical and medical products and global public health sectors. She holds MD and MBA degrees from Columbia University and did medical postgraduate training at Beth Israel Medical Center in internal medicine. She did her undergraduate studies at Boston College, where she was a presidential scholar. Dr. Parsons is a frequent presenter and panelist, focusing on quality improvement, EMR adoption, the patient-centered medical home, and regional extension center activities. She serves on the Board of Directors of VIP Community Service and the New York eHealth Collaborative, as well as the Advisory Board of the Touch Foundation.

Joel A. Perlman, executive vice president and chief financial officer, directs the financial planning and management activities of the Montefiore system. Mr. Perlman joined Montefiore Medical Center in 1988 as its chief financial officer (CFO). He previously served as CFO of Robert Wood Johnson Medical Center and St. Francis Medical Center, both in New Jersey. Prior to entering health care in 1980, Mr. Perlman worked for Ernst & Young, where he conducted numerous audit and consulting engagements for clients in manufacturing, banking and health care. Mr. Perlman received his bachelor's degree, magna cum laude, from Pace University and his master's degree from Columbia University. In 1977, he became a certified public accountant. Mr. Perlman is active in numerous professional associations and serves as the chairman of the fiscal policy committee of the Greater New York Hospital Association and chairman of the audit and compliance committee of HealthFirst, Inc.; he is the immediate past chairman of the board of

Linxus, a membership corporation comprised of the largest health insurers and hospital systems operating in the New York region.

Perry Pong, MD, is the chief medical officer at the Charles B. Wang Community Health Center. Dr. Pong directs clinical operations, including medical, dental, mental health, nursing, clinical informatics, and other ancillary services. He oversees the health center's Quality Assurance Program, monitors utilization, and develops long-term plans for programs and services. Dr. Pong received his AB degree in biochemistry from Harvard University and his MD degree from the University of California at San Diego. He is board-certified in internal medicine and serves as an adjunct assistant professor of medicine at the New York University School of Medicine. Dr. Pong is a board member of the Chinese American Medical Society and the Chinese American Independent Practice Association.

Ramanathan Raju, MD, is the executive vice president and corporate chief medical officer of the New York City Health and Hospitals Corporation. He started his professional career in India. He attended Madras Medical College to earn his medical diploma and subsequently did a residency in surgery and a fellowship in pediatric surgery. He underwent further training in England and was elected as a fellow of the Royal College of Surgeons. He later received further surgical training in the United States, culminating in a fellowship in vascular surgery. He is board-certified in surgery and is a fellow of the American College of Surgeons. He held the position of clinical professorship in multiple medical schools. He is actively involved in teaching residents and medical students and an avid researcher. Dr. Raju is also a physician executive, having obtained an MBA degree from the University of Tennessee. He currently serves as an adjunct professor in business management at the University of Tennessee. Positions he has held include director of surgery, director of trauma, director of surgical research, and director of medical education. Prior to his present position he served as the chief medical officer and chief operating officer of Coney Island Hospital.

Stephen Rosenthal is corporate vice president, network care management, for Montefiore's Integrated Delivery System. He is also the president and chief executive officer of the Care Management Company (CMO), a wholly owned for-profit subsidiary of Montefiore Medical Center. Mr. Rosenthal has been a leader in the development of programs and initiatives in care management interventions. These programs for frail and vulnerable populations have supported the

growth of Montefiore's integrated delivery system. As vice president of Montefiore's Professional Services, Mr. Rosenthal developed and managed Montefiore's Faculty Practice of over 800 physicians. Prior to that, he developed over a half a million square feet of ambulatory practice programs. He maintains an active role in and currently chairs the network-wide implementation of Montefiore's ambulatory clinical information systems. Mr. Rosenthal also spent a number of years practicing as a clinical audiologist. He holds a master's degree in science from Brooklyn College and a master's of business administration in finance and management information systems from Pace University. He is an associate in the Department of Epidemiology and Social Medicine of the Albert Einstein College of Medicine.

Steven M. Safyer, MD, is president and chief executive officer of Montefiore Medical Center. Dr. Safyer has been at Montefiore for 26 years, previously serving as senior vice president and chief medical officer. Throughout his medical career at Montefiore, Dr. Safyer has been a strong advocate for underserved populations, including those incarcerated and those affected by the public health crises of HIV and tuberculosis. He has built extensive primary care networks in poorly served areas, developed innovative business and clinical strategies to manage care and assume risk, championed the adoption of cutting-edge clinical information systems and created nationally recognized quality and safety programs. Dr. Safyer has authored and co-authored numerous articles in peer-reviewed journals, covering subjects ranging from electronic medical records to managing the health of a population, to tuberculosis in prison populations. Dr. Safyer received his bachelor of science degree from Cornell University and his medical degree from Albert Einstein College of Medicine. He did his internship and residency in social medicine at Montefiore. He is board certified in internal medicine and a professor of medicine in the Department of Medicine and professor of epidemiology and population health in the Department of Epidemiology and Population Health at Albert Einstein College of Medicine. He is a fellow of the New York Academy of Medicine and founding member of the Health Management Academy.

Lynn Sherman is the chief financial officer at the Charles B. Wang Community Health Center, overseeing the financial operations of the health center, as well as management information systems, human resources, and capital projects. She is treasurer and a member of the Board of Directors of Affinity Health Plan. She is also a member of the

Healthcare Information and Management Systems Society Ambulatory Community Health Organizations Task Force and the Healthcare Financial Management Association. Ms. Sherman has been involved with the Association of Asian Pacific Community Health Organizations and the Enabling Service Program, working to provide quality health care and to eliminate health disparities for people of Asian and Pacific Islander descent. She holds an MBA degree from Cornell University with a certificate in hospital and health service administration and a concentration in management information systems.

Michael Sparer, PhD, JD, is department chair and professor of health policy and management at Columbia University's Mailman School of Public Health. He studies and writes about the politics of health care. Much of his work focuses on the politics of public insurance programs, including Medicaid and Medicare, and ways in which intergovernmental relations influences health policy. He is the author of *Medicaid and the Limits of State Health Reform*. Dr. Sparer also developed and taught a Web-based class entitled "The Politics of Health Care," a six-part e-seminar produced by Columbia Interactive. Previously, he spent seven years as a litigator for the New York City Law Department, specializing in intergovernmental social welfare litigation. Dr. Sparer is a member of national advisory committees for the Robert Wood Johnson (RWJ) Foundation's Covering Kids and Synthesis programs, and won an RWJ Health Policy Investigator Award in 2003. He earned his PhD degree at Brandeis and his JD degree at Rutgers.

James R. Tallon, Jr., is president of the United Hospital Fund of New York. He is chair of the Commonwealth Fund and of the Kaiser Commission on Medicaid and the Uninsured. Mr. Tallon is also a member of the New York State Board of Regents, the constitutionally established supervisory body of all education and education-related activities in New York. During the gubernatorial transition period in 2006, Mr. Tallon headed New York's Health Care Policy Advisory Committee. From 1998 to 1999, he led the planning process that established the National Quality Forum. Mr. Tallon is a former member of the boards of the Joint Commission on Accreditation of Healthcare Organizations and the Center for Health Policy Development. He has held visiting lecturer appointments at the Columbia University and Harvard University schools of public health. Prior to joining the Fund in 1993, Mr. Tallon represented Binghamton and parts of Broome County in the New York State Assembly for 19 years, beginning in 1975. He chaired the health committee from 1979 to 1987 and was majority leader from 1987 to 1993. Mr. Tallon received a BA degree, cum laude,

from Syracuse University and an MA degree in international relations from Boston University. He has done additional graduate work at the Maxwell School of Citizenship and Public Affairs at Syracuse University. In 1995, he was awarded honorary doctorates of humane letters from the College of Medicine and School of Graduate Studies of the State University of New York Health Science Center at Brooklyn and from New York Medical College.

Patricia Wang, JD, joined HealthFirst as president and chief executive officer in March 2008. Before that, she was a senior vice president at the Greater New York Hospital Association (GNYHA) where she worked on health care finance policy, managed care, and advocacy at the local, state, and national levels. One of her first projects at GNYHA was the creation of a new model of a hospital-sponsored managed care plan, which became HealthFirst. Prior to joining GNYHA, Ms. Wang worked as a health care attorney for Kalkines, Arky, Zall and Bernstein. There, she specialized in matters affecting hospitals serving low-income and uninsured populations. Ms. Wang received an AB degree from Princeton University and a JD degree, cum laude, from New York University School of Law.

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.

Kathryn Linehan joined the Forum as a principal policy analyst in January 2009. Her areas of interest include private insurance markets and post-acute and long-term care payment systems. Before joining the Forum, Ms. Linehan was a consultant at Alicia Smith & Associates, where she worked with a number of states with Medicaid managed care programs. She worked with clients on developing, implementing, and evaluating various aspects of their Medicaid programs. Prior to her consulting work, Ms. Linehan analyzed Medicare payment issues with two congressional support agencies. For three years she analyzed skilled nursing facility and hospice

payment issues at the Medicare Payment Advisory Commission (MedPAC). Prior to that, she was a senior analyst at the General Accounting Office (GAO, now known as the Government Accountability Office) for five years, where she focused on various issues including Medicare+Choice, prescription drug, and physician payment policy. She has a bachelor's degree from Oberlin College and a master of public health degree from the University of Michigan School of Public Health.

Lisa Sprague is a principal policy analyst with the National Health Policy Forum. She works on a range of health care issues, including quality and accountability, health information technology, private markets, chronic and long-term care, and veterans' health. Previously, she was director of legislative affairs for a trade association representing preferred provider organizations and other open-model managed care networks. Ms. Sprague represented the industry to Congress, federal agencies, and state insurance commissioners; managed the association's policy development process; and edited a biweekly legislative newsletter. Ms. Sprague came to Washington in 1989 as manager of employee benefits policy for the U.S. Chamber of Commerce. Her interest in health policy arose in her earlier work as a human resources manager and benefits administrator with Taft Broadcasting (later known as Great American Broadcasting) in Cincinnati, Ohio. She holds a bachelor's degree in English from Wellesley College and a master of business administration degree from the University of Cincinnati.

CONSULTANT

William J. Scanlon, PhD, is a health policy consultant to the National Health Policy Forum. He is a commissioner of the National Committee on Vital and Health Statistics, a past commissioner of the Medicare Payment Advisory Commission, and a member of the Board of Directors of the Visiting Nurse Service of New York. 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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