

The Regents of the University of California

COMMITTEE ON HEALTH SERVICES

September 17, 1998

The Committee on Health Services met on the above date at UCSF - Laurel Heights, San Francisco.

Members present: Regents Atkinson, Chandler, Davies, Khachigian, Leach, Ochoa, and Preuss; Advisory member Vining

In attendance: Regents Bagley, Connerly, Espinoza, Gould, Hotchkis, Johnson, Kozberg, Lee, Miura, Montoya, and Willmon, Regent-designate Taylor, Faculty Representatives Coleman and Dorr, Secretary Trivette, General Counsel Holst, Provost King, Senior Vice President Kennedy, Vice Presidents Broome, Darling, Gomes, Gurtner, and Hershman, Chancellors Berdahl, Bishop, Carnesale, Cicerone, Dynes, Greenwood, Orbach, and Yang, Executive Vice Chancellor Grey representing Chancellor Vanderhoef, and Recording Secretary Bryan

The meeting convened at 9:10 a.m. with Committee Chair Khachigian presiding.

1. **AUTHORIZATION TO ESTABLISH A LIMITED LIABILITY CORPORATION WITH MERCY HOSPITAL AND HEALTH SYSTEM IN MERCED, SCHOOL OF MEDICINE AND MEDICAL CENTER, DAVIS CAMPUS**

The President recommended that he, in consultation with the General Counsel and Vice President of Clinical Services Development, be authorized to:

- A. Execute documents to establish a limited liability corporation (LLC) to be capitalized up to \$3 million by each member, consisting of The Regents and Mercy Hospital and Health Services (Mercy), for the purpose of constructing and operating a community cancer center (Cancer Center) in conjunction with Mercy Hospital.
- B. Execute a groundlease between the LLC and Mercy so that the facilities of the Cancer Center can be built and the facilities and equipment leased to Mercy.
- C. Approve a management services agreement whereby management services are provided by the LLC to Mercy.
- D. Approve a lease between the LLC and Mercy whereby Mercy leases employees to the LLC for the provision of all services to be provided at the Cancer Center, save and except radiation and medical oncology services.

- E. Execute an agreement between The Regents and Mercy whereby the UC Davis School of Medicine provides medical direction and professional services, including radiation oncology services.

It was recalled that the University of California, Davis, School of Medicine and Medical Center envision a leadership role in a regional, state-of-the-art cancer care network that will benefit the local community and the academic program. The Cancer Center will provide major academic benefits to the UC Davis Oncology Program, including: (1) an additional site for the training of residents in medical and radiation oncology; (2) an additional site for the conduct of oncology research; (3) expansion of UC Davis's telemedicine program in oncology; (4) community outreach by expanding the availability of academic medicine in the field of oncology; (5) opportunities in medical education for community physicians in the Merced area; and (6) supporting Mercy Hospital in Merced with tertiary and quaternary cancer services available at UCDCM. It is hoped that the Merced community will benefit from a higher quality of care, a broader range of local services, and instantaneous access to the UC Davis oncology expertise via the telemedicine services.

The Merced Cancer Center Transaction

An LLC will be established that will be capitalized by each member up to \$3 million and owned equally by each. The LLC will develop and contract for the construction of an outpatient Cancer Center to be operated under Mercy's general acute care license. The LLC will lease the vacant land from Mercy, have the facility built, either donate or purchase the equipment, and lease employees from Mercy, who will perform nursing, technical, and other outpatient services required for operation of the Cancer Center.

Each member of the LLC will appoint a manager and those managers will have full control of the LLC, with the exception of specific reserved powers. Management decisions will be made on a consensual basis. Mercy and The Regents will reserve the right to sell, exchange, or dispose of all or essentially all of the LLC's assets; to lease or purchase real property; to merge the company; to provide management services to a different hospital; to dissolve the company; and to file petitions in bankruptcy or reorganization.

In the event that there are disputes regarding the meaning of the terms of the LLC operating agreement, arbitration is mandatory; however, disputes between the managers over management or operation of the LLC will be referred to Mercy and The Regents for resolution. In the event of irreconcilable conflict, either party may withdraw from the LLC on 60 days' notice. In the event of the withdrawal of either party from the LLC, Mercy must pay the University for its interest at fair market value. Since the Cancer Center is an outpatient department of the hospital, the revenue stream of income to Mercy will be taken into account in determining fair market value. The fee payable to the LLC for the provision of services, facilities, and equipment is proposed to be the revenue generated from the operation of the Cancer Center.

Professional services will be provided to the Cancer Center under a contract between Mercy and UC Davis. The University will be responsible for radiation oncology services and for medical direction and coverage for such services. The key medical oncology services will be provided by a community physician who is likely to remain in private practice and lease space at the Cancer Center. The medical oncologist will have a faculty appointment with the UC Davis School of Medicine for purposes of providing research coordination, medical education coordination, and medical direction of oncology services at the Cancer Center.

Description of the UC Davis Partner

Mercy Hospital, a California religious corporation, operates a 101-bed general acute care hospital in Merced that was founded in 1923. The hospital has 200 physicians on its staff and employs 600. This facility provides emergency, obstetric, pediatric, intensive care, and general medical and surgical services.

Mercy is part of the Stockton-based St. Joseph's Regional Health, one of the largest and oldest health care delivery systems in the northern San Joaquin Valley. With five acute care hospitals, one psychiatric hospital, skilled nursing facilities, and several outpatient centers, St. Joseph's provides a continuum of care in the community, including preventive, ambulatory, rehabilitative, home health, hospice, mental health, and long term care. St. Joseph's was a founding sponsor of OMNI Health Plan, and has recently become the first hospital-based system to obtain a limited Knox-Keene license. Its provider network includes over 800 physicians. St. Joseph's is sponsored by the Dominican Sisters and is a division of Catholic Healthcare West, California's largest Catholic-sponsored health care system.

Benefits to the School of Medicine, UCDMC, and the Local Community

The following illustrate the benefits that will accrue to academic and clinical programs of the UC Davis School of Medicine and Medical Center as well as to Merced area residents.

The oncology research program will benefit through the increased volume of clinical trials in radiation and medical oncology. This will enhance the productivity of current trials and improve the ability of UC Davis to secure new contracts for clinical trials.

Research in telemedicine will be enhanced, as its widening use will allow additional applications for research in medical informatics, an area in which the School of Medicine is a leader.

Clinical teaching of residents and fellows will be enhanced by the Cancer Center's clinical volume and by the increased referrals to UC Davis projected for highly specialized outpatient oncology services such as bone marrow transplant, total body irradiation, high-dose-rate brachytherapy, and stereotactic radiosurgery. These referrals

are key to implementing the radiation oncology residency program planned for several years. It is proposed that future radiation oncology residents will rotate through the Cancer Center and be subject to the same rigorous standards as other UC Davis residents. Learning in the community environment will enhance the training of residents by expanding their interaction with, and resulting knowledge of, community-based primary care medicine; this is very difficult to achieve in a university medical center, and thus a strength in the proposed program.

Clinical teaching in other departments and divisions will be enhanced through the increased referrals expected for inpatient cancer services; the benefitted areas will include: neurological surgery, neurology, otolaryngology, urology, pediatric hematology/oncology, obstetrics and gynecology, (adult) hematology/oncology, and surgical oncology.

Comprehensive cancer center designation for the UC Davis Cancer Center will be supported by this project, which is one of many activities that will strengthen the UC Davis School of Medicine and Medical Center's application to the National Cancer Institute for this designation. The campus is currently in the first phase of this process, putting together an application for an NIH cancer center support grant.

Quality of care in the local community, Merced County, and its environs will benefit. The radiation oncologists will be credentialed as permanent or volunteer faculty and will rotate through the UC Davis Cancer Center in Sacramento. In addition, faculty from UC Davis will visit Merced for clinical care as well as grand rounds and continuing medical education initiatives. Patients will be admitted for treatment on national protocols that promise treatments years before they are available to the community at large. Cancer patients will also benefit from integrated quality assurance facilitated by visits and telemedicine for specific patients in Radiation Oncology. Most important, however, in raising the quality of local oncology care will be the permanent and timely communication that will be facilitated between the Cancer Center and the clinical oncology specialists of the UC Davis School of Medicine and Medical Center via telemedicine.

Access to cancer care will be improved as well. The Cancer Center will be able to treat a larger proportion of patients than the current oncology providers, obviating daily patient travel to distant towns for care, a major concern for patients debilitated by their disease and on occasion by the side effects of treatment.

Financial Obligations and Risks

The University's initial capital contribution will not exceed \$3 million and will be matched by Mercy. Current capital requirement projects include approximately \$1.1 million in capital and will be used for radiation therapy and other equipment, approximately \$1.3 million for building design and construction, with the remaining funds allocated for development costs, start-up, and contingency to cover projected

operating losses. The remaining \$600,000 from the initial capital contribution is expected to cover development costs, start-up, and to cover projected initial operating losses. On the basis of the financial forecasts developed jointly with Mercy, it is anticipated that some losses will be incurred in the first three years of operation. It is anticipated that minor losses will be incurred by the operation and that the University's portion of those losses will be made up by UCDMC. Not included in the projections are anticipated financial gains associated with referrals for specialty outpatient and inpatient oncology services at UCDMC. These gains will partially offset the anticipated losses from the Cancer Center.

Regent Leach noted that the project is expected to lose about \$250,000 a year for three years. He asked if there were a cap on these losses. He stated that, while he was supportive of the proposal from an academic point of view and as a service to the community and patients, he was concerned about entering into a situation in which losses could escalate unchecked. He cited the Western Health Advantage project, which, when it was presented to the Regents, committed the Medical Center to \$500,000 for capital and \$1 million to qualify for a Knox-Keene license. The revenues and expenses were projected to be about \$1.5 million, with a positive operating income of \$2,000. It was reported this month that the Medical Center has put in \$4.2 million to date and is projected to put in another \$6 million. The statement is included that the project is expected to break even sometime after 2000. Regent Leach believed that caps should be put in place in this kind of arrangement in order to assure that the people with responsibility for administering it either have to perform to that standard or return to The Regents for further approval. Regent Hotchkis agreed.

Mr. Gurtner noted that The Regents now review every such project within 24 months of its inception. He preferred that method to imposing caps. He believed that the first review should take place after a project has had enough time to get through the vagaries of starting up. He noted that both projections and caps may be arbitrary. He suggested approving the recommendation as presented in order to allow him time to return at the next meeting with an appropriate spending limit. Chairman Davies suggested that rather than imposing a cap, the Regents should be informed immediately when there is a material shortfall. Regent Leach agreed that taking such action would achieve his purpose. Mr. Gurtner agreed to return to the Committee with a plan to meet the proposed review process. Chief Operations Officer Robert Chason preferred that as an alternative. He noted that safeguards have been built into the agreement that would protect the University in the event of unanticipated difficulties.

Regent Preuss commented on the principal safeguard in the agreement, a 60-day withdrawal notice. He wondered whether it may be too short. Mr. Chason believed that Mercy Hospital would be willing to consider a longer span. He emphasized that the community invited the University to participate in this arrangement and was anxious to become associated with it. In answer to a question by Regent Ochoa, he explained that the venture has no connection with UCSF's Fresno site and that there has been minimal opposition within the community to the Mercy Hospital plan and a great deal

of support for it. Regent Chandler applauded the project as a way of bringing specialized care to Merced County. She believed that the benefits far outweigh any concerns that had been expressed.

President Atkinson indicated that he would send the Regents a letter in which he would describe in detail the nature of caps to be imposed on losses in agreements such as the one under discussion, the review process for this kind of project, and the scope of the exit strategy. Committee Chair Khachigian believed this would address the concerns some Regents had expressed. She instructed them to inform her if they had further questions after having received the President's letter.

Committee Chair Khachigian observed that the item under consideration had not been previewed by the Regents. She requested that all similar proposals be brought to the Board as informational items or be discussed with the Committee Chair a month before being presented for action.

Upon motion duly made and seconded, the Committee approved the President's recommendation and voted to present it to the Board.

2. **APPROVAL OF RESOLUTION SUPPORTING UC HEALTH SCIENCES CLINICAL ENTERPRISE CORPORATE COMPLIANCE PROGRAM**

The President recommended approval of the attached resolution (Attachment) in support of a Universitywide Health Sciences Clinical Enterprise Corporate Compliance Program.

It was noted that the business of health care is under unprecedented scrutiny and demands for accountability. The complex regulations surrounding reimbursement by government and private payors for clinical enterprise activities have led to increased government audits of health care practices and legal actions against providers. In some cases, these audits have resulted in significant financial settlements for the audited clinical enterprise and negative publicity for the institutions and health care providers. Nationwide, academic health centers and non-academic medical centers are implementing corporate compliance programs that demonstrate their commitment to ethical and legal behavior in carrying out the business activities of the clinical enterprise.

It was recalled that at the June 1998 meeting of The Regents, The Regents authorized the President, in consultation with the General Counsel and the Vice President of Clinical Services Development, to develop a Health Sciences Clinical Enterprise Corporate Compliance Program (Program). The General Counsel and the Vice President of Clinical Services Development, in consultation with the systemwide Clinical Enterprise Corporate Compliance Committee, have determined that the Program and the supporting Code of Conduct should reflect a commitment to the following:

- Ethical and legal behavior in carrying out the activities of the health sciences clinical enterprise;
- Specific standards of ethical and legal conduct (Standards) that address areas of most significant risk, as identified by the United States Department of Health and Human Services/Office of the Inspector General and other regulatory agencies;
- Clear communication of the expected Standards to all employees;
- Preventing, reporting, and responding to violations of the Code of Conduct and Standards;
- Universitywide monitoring of health sciences clinical corporate compliance while allowing for significant flexibility at the campus level through the development of a Health Sciences Clinical Enterprise Corporate Compliance Plan (Plan) at each academic health center;
- Consistency between the objectives of each academic health center Plan and the University's tripartite mission;
- The influence of the Plan's objectives on health sciences clinical enterprise governance, risk management, information management, and financial and operational activities;
- Mechanisms to monitor the effectiveness of the Plan at periodic intervals;
- Annual reports to the Board of Regents regarding the status of compliance with the Plan; and
- The current policy and procedures for professional fee billing compliance as approved by The Regents in the *Health Sciences Campus: Professional Fee Billing Compliance Plan Guidelines* (October 1996).

The Health Sciences Clinical Enterprise Code of Conduct is being finalized by the systemwide Clinical Enterprise Corporate Compliance Committee in coordination with General Counsel. This systemwide Code of Conduct will provide the framework for each of the University's academic health centers to develop campus-specific Plans and will address a number of issues, including, but not limited to, the following:

- Quality of care;
- Unlawful or improper referrals and kickbacks;
- Cost reports and billing/coding practices;

- Antitrust;
- Conflicts of interest; and
- Medical necessity.

At a future meeting of The Regents, each academic health center campus will provide an update of its campus-specific Plan and health sciences clinical enterprise corporate compliance activities.

The proposed resolution demonstrates The Regents' support for the systemwide Program and University of California employees in their ongoing efforts to enhance and maintain the University's meritorious reputation for preeminence in care, education, and research.

Upon motion duly made and seconded, the Committee approved the President's recommendation and voted to present it to the Board.

3. **UPDATE ON WESTERN HEALTH ADVANTAGE, MEDICAL CENTER, DAVIS CAMPUS**

It was recalled that, according to The Regents' Bylaw 12.7(b), the Committee on Health Services is responsible for "all matters related to business transactions affecting the clinical services of University academic medical centers and schools of health sciences including, but not limited to, acquisition of physician practices, hospitals, and other facilities, clinical and ancillary services, and participation or membership in joint ventures, partnerships, corporations, or any other entities..."

Beginning with the presentation of the UCSD/Boehringer-Mannheim joint venture, presented to The Regents in July 1998, the Division of Clinical Services Development has committed to providing status reports on business transactions approved by The Regents. The following is the second status report provided to the Board of Regents for review.

Status Report on Western Health Advantage

Director Shannon discussed the background of the Western Health Advantage project, noting that it was formed following the announcement in 1994 that the Medi-Cal program in Sacramento County would be moved to a managed care model. At the July 1995 meeting of The Regents, the Committee on Health Services authorized UC Davis Medical Center (UCDMC) to join with Mercy Healthcare, Woodland Healthcare, and NorthBay Health System to form Western Health Advantage (WHA), a nonprofit public benefit corporation. Designed as a provider-sponsored health plan, Western Health Advantage was intended to give more local control over medical services and compete with traditional health maintenance organizations for capitated lives in its seven-county service area, including Solano, Yolo, and Sacramento Counties, southern Sutter County, and western portions of Placer, Nevada, and El Dorado Counties.

The Regents authorized UCDMC to contribute up to \$1,500,000 of reserves in support of the project, which included \$114,000 to finance its share of start-up expenses, \$26,000 for the first year of operations, \$300,000 to develop and secure a Knox-Keene license, a contingency fund of \$60,000, and a tangible net equity of at least \$1,000,000 towards application for the Knox-Keene license. In the case of WHA dissolution, the license would revert to UCDMC. The Regents' item was silent on additional funding of operational losses associated with UCDMC's participation in WHA, though attachments included estimates of the Management Fees which would be paid by UCDMC to WHA to support operations.

The Division of Clinical Services Development has reviewed the strategic goals, objectives, and the current status of this collaborative relationship. Though many of the original goals, including strengthening relationships with other provider groups in the Sacramento market and development of direct health care contracts with both government and commercial payers have been met, regulatory and health care market

changes have resulted in higher than expected ongoing financial support to the organization. Based on discussions with key UCDMC personnel regarding the future direction of WHA, however, and when assessed against a broader strategic context, Clinical Services Development has come to the conclusion that this alliance has produced several benefits to UCDMC in terms of increased numbers of managed care contracts, increased referrals from outlying areas, and greater training opportunities for its residents, helping UCDMC strengthen and expand its presence in Northern California.

UCDMC first decided to secure a Knox-Keene license in 1994 when the State announced its plans to move the Medi-Cal program in Sacramento County to “full-risk” capitation for both inpatient and outpatient services. UCDMC thought the step was necessary to minimize the risk of losing a significant number of Medi-Cal patients who were important to the teaching and research programs of the School of Medicine. For both economic and strategic reasons, UCDMC decided to acquire a Knox-Keene license jointly with Mercy Healthcare, Woodland Health, and the NorthBay Health System. By joining these organizations, UCDMC spread the financial costs and risks of starting an HMO and enhanced the marketability of any insurance products it elected to offer to public- and private-sector employers.

WHA is only one of several strategies that have been pursued by UC Davis during the past five years in response to an environment that is dominated by HMOs and “full-risk” contracts that reimburse providers a fixed amount per enrollee on a monthly basis. Other major initiatives include:

- The development of a Primary Care Network serving over 250,000 residents in 18 Northern California communities;
- The UCDMC Community Hospital Network, a dozen hospitals collaborating to improve the quality and availability of health services in Northern California;
- UCDMC telemedicine program linking with providers in several Northern California communities; and
- The establishment of several centers of excellence that include strong clinical programs and research components.

Goals for WHA

The July 1995 Regental action referenced three specific goals for WHA:

- To facilitate development of new partnerships and contracts with organizations that pay for health care services. This initiative provided a vehicle for UCDMC to strengthen its relationship with Mercy Healthcare Sacramento, a major force in the regional marketplace. Through WHA and other parallel initiatives,

UCDMC is attempting to forge a broader strategic alliance with Catholic Healthcare West (the parent organization of Mercy Healthcare Sacramento).

- To provide a vehicle to develop and market niche products, such as Medicare risk, Workers' Compensation, and products geared toward small businesses.
- To provide a vehicle to help negotiate contracts directly with employers and governmental agencies. As of May 1, 1997, WHA provides health care services to Medi-Cal beneficiaries in Sacramento and Yolo counties under the Geographic Managed Care Program. As of August 1, 1997, WHA entered into contracts to provide health care services to more than 16,000 commercial members (primarily small businesses) on a capitated basis.

Governance

The 1995 Regental action specified that WHA would be governed by an eight-member board of directors, with two representatives from each of the four charter members. Several major actions could be taken only with the approval of 75 percent of the Board members. The University (or any member) would have the option to withdraw from WHA upon 90 days' written notice. In the case of dissolution, any WHA assets would be redistributed based on the percentage of capital contributions made.

Early in 1997, Mercy Healthcare Sacramento acquired Woodland Healthcare, and the WHA Board unanimously agreed to modify the bylaws so that UCDMC, Mercy, and NorthBay Health system would have three members each. More recently, the Board membership was modified to include a member of the general public. The UCDMC Associate Director for Clinical Affairs is currently chairman of the WHA Board of Directors. At the present time, the position of CEO for Western Health Advantage is vacant; a national search is under way.

Status Report

WHA was formally incorporated in August 1995. It received its Knox-Keene license in January 1997 and began providing services to Medi-Cal capitated patients in May 1997, and began offering a commercial HMO product in August 1997.

The July 1995 Regents' item projected that total enrollment for capitated lives in FY 1998 would average 38,600, (32,100 Medi-Cal, 1,700 Medicare, and 4,800 commercially insured patients). As of June 30, 1998, WHA had 26,300 enrollees, of whom approximately 14,600 are Medi-Cal beneficiaries cared for by UCDMC physicians. The other 11,700 enrollees are "commercial" patients, 75 percent of whom are employees of WHA member organizations.

While total enrollment has fallen short of the initial projections, commercial enrollment is greater than anticipated. Several major factors have contributed to the gap between overall projected and actual enrollment:

- State approval of the Knox-Keene license occurred approximately five months later than originally expected;
- For both financial and strategic reasons, the WHA Board elected to delay its participation in Medicare Risk by approximately 24 months;
- Because of the success of other UCDCMC initiatives in attracting a sufficient patient base to support teaching and research, UCDCMC chose not to pursue additional Medi-Cal patients through WHA.

Projections for the next two years show a 105 percent increase in overall enrollment. Commercial enrollment is projected to increase by more than 27,000 lives while Medi-Cal enrollment is expected to decline slightly by FY 2000.

In addition to the initial contribution by UCDCMC of \$1.5 million, the original project summary included projections of the management fees which would be paid by the members to support operations. The management fees would be based on a percentage of the total medical services premiums generated by WHA, and were projected to be 9.4 percent in FY 1996, 4.4 percent in FY 1997, and 3.2 percent in FY 1998. Management fee assessments to UCDCMC were actually lower than projected, because of lower enrollment.

The WHA organization was originally envisioned as a management company only, which was not at financial risk for any medical services. During the development phase, the Department of Corporations, which oversees health care service plans, required that WHA accept risk for selected services (pharmacy and out-of-area claims). Consequently, staffing and administrative costs assigned to the WHA management company are higher, and the costs assigned to participating provider organizations are lower, than would otherwise have been expected. Combining capital contributions, management fees paid, and additional support to cover operating losses, UCDCMC has invested \$4,183,006 to date, approximately \$721,000 more than first projected. As stated earlier, however, much of this additional expense is related to the transfer of risk for pharmacy and out-of-area claims from provider members to the WHA organization.

Financial statements for Western Health Advantage show a net loss of \$2.2 million in FY 1997 and an additional net loss of \$2.4 million in FY 1998. WHA is projected to lose another \$3.4 million in FY 1999. UCDCMC will be responsible for approximately one-third of additional financial support needed to cover these losses, in addition to the payment of ongoing management fees.

The increased projected shortfall in 1999 relates to two major areas:

- The cost of additional personnel, marketing, and other operational expenses linked to the development of a Medicare Risk product and a PPO product.
- The cost of implementing a Quality Data Information System (QDIS), a clinical and financial system for quality assurance activities, financial management, and utilization management. This system will require an investment of approximately \$1.2 million during the coming year. The annual operating cost of the new system is expected to be shared by WHA member organizations.

With the additional expenses, WHA is not projected to break even until after 2000. Detailed financial projections for years 2001 and beyond are not yet available.

Benefits to UCDMC

UCDMC's total investment in WHA to date has been \$4.2 million, with anticipated additional support of \$6.0 million in management fees and capital over the next few years necessary to bring the organization to the break-even point. In return for this investment, UCDMC has received substantial benefits, including:

- **Contracting:** Because of its regional focus, WHA represented a stronger opportunity to attract new patients in capitated health plans than could be achieved by UCDMC acting alone. As of July 1998, WHA has contracts with 398 groups that represent the commercial membership. WHA has specifically included UCDMC for all services, including primary care.
- **Economies of Scale:** The size of WHA would allow all participants to jointly share fixed overhead costs associated with the administration of full-risk capitation agreements. WHA members are currently discussing the possibility of utilizing QDIS to support activities related to HMO patients associated with other health plans. If WHA elects to pursue this possibility, a portion of the annual operating cost of the new system (\$1.2 million) will be shared by WHA member organizations. Additionally, WHA enabled UCDMC to share the cost of developing the Knox-Keene license with other organizations. Since UCDMC planned to pursue this license with or without WHA, UCDMC avoided approximately \$400,000 - \$600,000 in additional costs that would have been incurred if it had independently tried to secure the license.
- **Increased referrals to UCDMC:** Patient transfer agreements between WHA members would be priced lower to encourage such transfer, and were expected to generate additional referrals to UCDMC. Inpatient referrals to UCDMC from outlying areas grew by more than 25 percent from 1996 to 1998, resulting in a \$12 million increase in net income, partly as a result of relationships that evolved from the formation and implementation of WHA.

- **Training Opportunities:** WHA would expand the possible options for training sites and would enhance the possibility of long-term training relationships with WHA partners. Initiatives through WHA have provided new residency training program opportunities in several communities, including Woodland, Yuba City, and Sacramento. Training program affiliations with Mercy now include family and community medicine, pediatrics, surgery, and neurology.

Future Strategic Direction

Continued growth in WHA enrollment is critical to its financial success and to reduce further financial dependence on its members. In order to achieve the significant enrollment growth projected, WHA will have to make inroads in marketing to larger employers. Aside from employees of WHA providers (UC Davis, Mercy, and North Bay), commercial enrollees in WHA are almost exclusively associated with small businesses.

Based on recent discussions with brokers and health benefits managers, the most significant barrier to securing contracts with large employers is the lack of a Medicare Risk product and the lack of other products that would give consumers more flexibility in choosing a health care provider (i.e., a Point of Service plan). While enrollment in these products is expected to be small, having such options available is deemed essential to having access to the employees of many large employers.

Several factors will contribute to growth in WHA enrollment during the next two years:

- The ability to offer a Medicare Risk product will significantly enhance the marketability of WHA to UC Davis retirees as well as to the growing population of seniors in the local marketplace. The full impact of this is anticipated to materialize after FY 2000.
- The WHA service area is being expanded to include El Dorado, Calaveras, Placer, and San Joaquin Counties.
- WHA is exploring the possibility of developing other insurance options.
- WHA is pursuing contracts with large public and private sector employers.

Regent Leach expressed his concern about the amount of money that has been expended on the WHA project and the amount that is projected to be spent in the future. He noted that while the project has brought increased referrals and training opportunities, those benefits may not be worth unlimited costs. He requested a subsequent report that sets financial parameters. He also suggested that the Regents should be informed immediately when there are material changes in either projected or actual financial outcomes for this type of affiliation. Vice President Gurtner responded that it was his intention to formulate a strategic plan for addressing the problems

experienced in the partnership with WHA and to present his response at the November meeting. Chairman Davies suggested that interim reports with performance monitors be provided to the Regents. Regent Preuss asked that the next report make a very strong case as to why the administration believes the WHA joint venture should be continued. Faculty Representative Dorr agreed that a reexamination of projects may be necessary from time to time, but she urged the Regents to keep in mind the long-term benefits to the education and research missions of the University when evaluating these affiliations.

Regent Ochoa asked whether UCD offers a sufficiently high standard of care to enable it to compete in the marketplace. Chief Operations Officer Chason believed that UCD has a very good reputation and is capable of increasing the number of enrollees to the level envisioned in the strategic plan. He noted that UCDCMC has been one of the University's most successful centers in its ability to recruit commercial lives. Regent Gould asked that Mr. Gurtner's next report address the issue of how it is planned to make this venture profitable, how the teaching and research aspects of the joint venture will be addressed, and how enrollment on the commercial side is to be increased. Mr. Chason reported that UCD management is focusing currently on sustaining Medi-Cal population enrollments and on other issues having to do with the joint venture about which the Regents have expressed concern.

Regent Leach expressed his respect for and confidence in the University's managers. He believed that the November review of WHA will provide the details that are necessary to help the Board determine where its responsibility lies with reference to the project.

4. **UPDATE ON SANTA MONICA HOSPITAL PURCHASE, LOS ANGELES CAMPUS**

Director Shannon presented the third status report on the Santa Monica Hospital purchase. It was recalled that at the July 1995 Regents' meeting, the Committee on Health Services approved the purchase of selected assets of Santa Monica Hospital Medical Center, a California nonprofit public benefit corporation, by UCLA Medical Center for a purchase price not to exceed \$54,000,000. The Regents acquired Santa Monica Hospital Medical Center (SMHMC) August 8, 1995 for a total purchase price of \$51,650,000. The total value of assets acquired is \$72 million, or \$ 20,350,000 million more than the final purchase price. Following the acquisition, SMHMC and UCLA Medical Center combined their operations and SMHMC was renamed Santa Monica – UCLA Medical Center.

The Department of Clinical Services Development has reviewed the purchase of SMHMC in terms of its meeting strategic, financial, and programmatic goals. Based on discussions with key UCLA personnel, an assessment has been made about the future direction of the combined facility.

Although the acquisition of Santa Monica Hospital met its primary programmatic objectives, namely increased access to UCLA's market base in West Los Angeles and support of the UCLA primary care residency training program, the facility itself did not meet its financial projections, sustaining approximately \$11 million in financial losses since 1996. When viewed within the context of UCLA's regional strategy, increased system benefits have resulted. Since the acquisition, average daily census for the combined UCLA hospitals has increased by 60 patients per day, a substantial number of which are from UCLA's west side service area. While it is difficult to evaluate the enterprise had Santa Monica not been purchased, it appears the consolidation of operations has been a successful response to market pressures in the Los Angeles market. UCLA's consolidated operations resulted in \$125 million of combined net income over the last three years, \$104.5 million greater than projected.

As capitated enrollment grows, Santa Monica Hospital, as a low cost provider, will be critical in sustaining the positive financial performance of UCLA as a whole. Continued integration of this facility with UCLA is recommended to support the comprehensive strategy necessary to thrive in UCLA's service area. These and other steps are expected to improve the financial picture at UCLA/Santa Monica.

Market indicators in 1995 showed a 30 percent HMO penetration rate in UCLA Medical Center's primary service area, comprising approximately 100,000 enrollees. This percentage was growing rapidly, with increasing numbers of people leaving the higher-cost PPOs and traditional fee-for-service insurance and enrolling in lower-cost, restrictive HMOs. UCLA Medical Center, a major tertiary and quaternary care provider in its service area, needed to create a network of primary care providers to

retain and expand its patient base for primary care training and for managing the health care needs of its local population.

In support of its primary care strategy, UCLA Medical Center developed five community-based satellite primary care offices in its service area. Further, it affiliated with 55 members of two IPAs at Santa Monica Hospital and also signed a contract with Huntington Provider Group, one of the largest physician groups in Central and Southern California, to gain access to HMO contracts. A third component of its strategy was to develop a “financially integrated relationship with a low-cost, managed care-oriented community hospital,” such as Santa Monica Hospital Medical Center.

Objectives

UCLA Medical Center acquired the assets of Santa Monica Hospital Medical Center to support two specific objectives in its primary service area:

- The continued access to the population in West Los Angeles and Santa Monica – The purchase incorporated Santa Monica Hospital’s patients into the UCLA health care system. Prior to the acquisition, one-third of UCLA Medical Center’s patients originated from the West Los Angeles and Santa Monica markets. Currently, one-half of UCLA patients reside in these market areas.
- The expansion of UCLA School of Medicine’s primary care training programs -- The Family Practice Residency program at Santa Monica Hospital has continued, permitting UCLA graduate medical students to gain primary care training in a community hospital setting. Fifty residents participated in this program in 1996 and 1997, with twenty-five currently enrolled in 1998. Had Santa Monica Hospital been purchased by its local competitor, St. John’s Hospital, it is unlikely that UCLA’s Santa Monica residency program would have survived.

Status Report

UCLA’s market environment continues to be dominated by managed care. Organizational consolidation has escalated statewide, creating a market of managed care giants. In the Los Angeles marketplace, only five HMOs control 80 percent of the managed care enrollment. Providers have likewise consolidated. For example, Tenet Healthcare now owns and operates four facilities in West Los Angeles, UCLA’s primary service area. Tenet also owns and operates the USC University Hospital, a competitor to UCLA Medical Center in tertiary and quaternary care. Consolidating UCLA Medical Center operations with those of Santa Monica Hospital has been an important component of a successful response to market pressures in the Los Angeles market.

At the time of the acquisition, Santa Monica Hospital contracts included 26,500 capitated lives. Since a number of community-based physicians chose to leave Santa Monica Hospital following its acquisition by UCLA, approximately 40 percent of enrollees migrated with their physicians out of the UCLA health care system to St. John's Hospital.

UCLA's response included increased recruitment of community physicians, while continuing to work with its two IPAs and the Department of Medicine to develop the Primary Care Network. Both primary care physicians historically associated with Santa Monica Hospital and newly recruited physicians joined the Network, and increased enrollment is expected. The Network now includes twenty community-based primary care offices, up from five in 1995. Both commercial and Medicare enrollees may now choose UCLA physicians on the Westwood campus, or in the Network of off-site Medical Group offices. During this time UCLA also signed new capitated agreements via the Huntington Provider Group for managed care enrollment in the west side. Huntington Provider Group has steadily increased referrals of tertiary and quaternary patients to UCLA.

Consolidation of selected Santa Monica Hospital functions with UCLA's Westwood Medical Center has led to decreased expense. The following departments were consolidated with Westwood/UCLA Medical Center to reduce duplication and increase operating efficiency: Information Systems, Clinical Engineering, Public Relations, Pharmacy, Respiratory Therapy, Cardiology, Radiology, Nuclear Medicine, Rehabilitation Medicine, and Microbiology. In addition, use of group purchasing through the University HealthSystem Consortium has resulted in further savings.

Santa Monica Hospital continues to operate at a lower cost per patient day than Westwood/UCLA Medical Center. Santa Monica's 1998 adjusted cost per discharge is \$6,775 compared to \$8,473 at Westwood. As capitated enrollment grows through the Primary Care Network, Santa Monica Hospital, as a low-cost provider, will be critical in sustaining the positive financial performance of UCLA as a whole. Similarly, Santa Monica can accommodate overflow volume from Westwood, and serve as the UCLA site for lower acuity services, such as orthopedics.

Santa Monica Hospital was expected to incur losses for the first two years, to be offset by operating gains at UCLA Medical Center. The first three years have resulted in financial losses significantly greater than anticipated at Santa Monica Hospital. Santa Monica Hospital's cumulative net loss is \$10.8 million. This variance is primarily due to the following:

- The migration of physicians from Santa Monica Hospital to St. John's Hospital resulted in the loss of 40 percent of Santa Monica's enrolled population upon contract renewal in December 1997. In addition, these physicians represented approximately 20 percent of non-capitated volume, which likewise migrated away from Santa Monica Hospital beginning in December 1995.

- Deloitte & Touche performed a financial audit in 1997. The audit revealed that future contract losses were not recorded as recommended by the Financial Accounting Standards Board. The purpose of this expense is to fund contract losses in the event that capitated contracts are cancelled. This resulted in a \$2.5 million one-time expense in 1997. Compliance with this accounting standard was not included in the original financial projections for Santa Monica Hospital.
- The primary risk of the acquisition of Santa Monica Hospital was cited as the ability “to make the operational and organization changes necessary to eliminate current operating losses.” This continues to be the case. The cost containment plan included in the original financial projections proved to be too optimistic. Current operations have improved, as costs at UCLA/Santa Monica have decreased from an average \$7,415 to \$6,775 per discharge. Net Income was positive in 6 of the last 7 months of fiscal year 1998, with break-even operations anticipated in fiscal year 1999.

As a combined entity, the integration of Santa Monica with UCLA resulted in positive operating returns. The consolidation of hospital functions, an integrated managed care strategy, and expansion of the Primary Care Network have contributed to improved financial performance. Consolidated operations of Santa Monica Hospital and UCLA Medical Center generate positive financial results each year, far in excess of projected levels. Combined Net Income rose 104 percent from 1996 to 1997, with cumulative net income of almost \$125 million since 1996.

Future Strategic Direction

The future strategic direction of Santa Monica Hospital continues to be that of an integrated component of UCLA’s overall strategy. The infrastructure of UCLA/Westwood supports operations for both Santa Monica and UCLA’s Neuropsychiatric Hospital. In turn, these sites add flexibility to the system in terms of geographic access, lower-cost sites for lower acuity services, and support for continued expansion of the Primary Care Network. Market pressures engendered by managed care are not likely to abate in UCLA’s service area. These continuing pressures must be met with a comprehensive market-based strategy that includes all UCLA facilities.

The first phase of this integrated strategy is the appointment of a permanent chair for the newly created Department of Family Medicine. A key task for this position, anticipated to be filled by January of 1999, is to further expand UCLA’s primary care teaching and residency programs through the Primary Care Network. The residency training programs at Westwood and Santa Monica are currently separate and distinct. They will become integrated under the new chair as Santa Monica physicians continue to earn faculty appointments at the UCLA School of Medicine.

Further consolidation of operations and clinical initiatives is another phase of UCLA's strategic response to its market. Without the Santa Monica acquisition, for example, the Orthopedic Alliance (approved by The Regents at the June 1998 meeting) would not have been possible. It is anticipated that moving orthopedic services to Santa Monica will enhance some ancillary services, such as Radiology, for all patients at the facility.

Finally, construction planned at Westwood and Santa Monica sites will support the complementary services offered at each site. New construction at Santa Monica is designed to support primary and secondary care, while that at Westwood is focused on its core competency, the delivery of tertiary and quaternary care. These construction projects are scheduled for review and discussion by The Regents over the next several months.

Medical Center Director Karpf highlighted the ways in which the Santa Monica Hospital fits into a broad strategy and affects all the missions of the University. He noted that, although UCLA enjoys a national and international reputation for being an institution that is at the forefront of taking biomedical findings and inventions and new data and translating them into everyday healthcare, it is a much more complex organization than that. In 1995, before the acquisition of Santa Monica, approximately 31 percent of patients came from UCLA's primary service area, which is contained within a seven-mile radius that includes Manhattan Beach, Malibu, Sherman Oaks, Hollywood, and Culver City. At the end of this last fiscal year, the percentage of patients coming from the primary service area had increased to 48 percent. These patients are critical to the fiscal integrity of the hospital, but the primary service area is also important for the Medical Center's other missions. UCLA has made a commitment to expanding and emphasizing primary care education. As an institution with a very strong interest and fundamental commitment to tertiary and quaternary care and biomedical education, it was important to develop appropriate sites and mentors and an environment in which primary care could be recognized for what it does. The west side strategy emphasizes and enhances the Medical Center's ability to teach primary care and to develop role models and demonstrate lifestyles for its students and residents. The campus' efforts on the west side of Los Angeles are also critical to its research efforts. The west side is a market in turmoil, the crucible of managed care at this time. UCLA has to be a major participant in the managed care environment if it is going to offer commentaries on the change in healthcare.

Mr. Karpf believed that in order for UCLA to participate in its primary service area, it needed to develop an integrated delivery network that would move UCLA into the community and increase its accessibility in a dramatic fashion. The components of an integrated delivery network are a primary care network, a community low-cost hospital with a friendly environment, a tertiary or backup facility such as UCLA Medical Center, integrated information systems, and aligned incentives. The acquisition of Santa Monica Hospital is a component of that integrated delivery network that is being forged. The primary care network now consists of 21 sites that address the

marketplace in a cohesive fashion. It has required a substantial commitment of resources that will need to be evaluated over time.

Committee Chair Khachigian asked why so many enrolled patients left Santa Monica Hospital for St. John's and why the exodus could not be anticipated. Mr. Karpf explained that the IPA at Santa Monica had individuals committed to the Santa Monica Hospital and to St. John's. When it became clear that UCLA was going to get involved with Santa Monica, those individuals who had affiliations with St. John's moved their practices and patients. It was a partitioning of the marketplace. He believed one would have to be very forward looking to understand every exigency that could happen in a marketplace like that. Relationships between physicians and hospitals and physicians and various groups are fluid and are sensitive to changes in reimbursement and contracting. No one could have anticipated all the events that happened. Committee Chair Khachigian believed that such probabilities should have been ferreted out before any commitment was made.

Regent Kozberg asked what the impact of a fully renovated, state-of-the-art St. John's hospital was expected to be on the Santa Monica Hospital. Mr. Karpf reported that St. John's capacity could be 150 beds. Before the earthquake, it had an average daily census of 300. Santa Monica's anticipated average daily census after renovation will be about 186. The total aggregate of beds on the west side of Los Angeles is declining and may continue to do so, because facilities unable to comply with seismic requirements may have to close. He believed that in the future, some patients may choose to go to St. John's and some may decide to return from St. John's. The main allegiance patients have now is to their primary care physicians. He believed that the UCLA system has to have the ability to serve patients in effective, friendly ways that earn their allegiance.

Regent Gould was encouraged to hear that there is going to be some downsizing in the number of beds on the west side. He asked about the Medical Center's current utilization. Mr. Karpf reported that the average daily census is 440 at UCLA's Westwood hospital, 60 at the Neuropsychiatric Hospital, and 145 at Santa Monica Hospital. It is anticipated that when the new Santa Monica Hospital opens, it will average 180 and that the completed system will run at about 85 percent of capacity. President Atkinson suggested inviting all of the Regents to briefing sessions at UCLA, where they can learn more about the system and the local healthcare environment.

Regent Leach observed that the Santa Monica center is a good example of a project that did not meet the Regents' original expectations. He noted, however, that because of cost containments, losses for the current year have been reduced substantially, and the hospital is expected to show a profit within two years. He asked that if the financial forecast changes and a loss of more than \$1 million is indicated, or if actual numbers reach that amount, the Board be notified.

President Atkinson commented that before a Vice President for Clinical Services was appointed, projects that were developed at the campus level were reviewed at the Office of the President, where there was not a great deal of specialized expertise, and were presented to the Board for approval. Once approved, the Board would never see them again unless major losses occurred. There now exists an ongoing, continuous interaction with each medical center, and Mr. Gurtner and various members of his team visit regularly to monitor each issue. The notion of a two-year review on each project is part of this effort to keep the Board informed not of just the comprehensive situation but of the individual situations. Appointment of the Clinical Policy Review Team is another reflection of the Office of the President's intention to keep the Board informed. Regent Preuss indicated that he has felt more fully informed about matters at the medical centers since Mr. Gurtner's arrival.

5. **ANNUAL REPORT OF THE CLINICAL POLICY REVIEW TEAM**

Vice President Gurtner introduced Dr. Joe Tupin, who summarized the annual report of the Clinical Policy Review Team, which examines whether the campuses are carrying out the University's various policies relative to the clinical enterprise function and provides advice to campuses on issues that arise. Dr. Tupin noted that the team includes University Counsel Joanna Beam, Director Cathryn Nation, and Coordinator Roseanne Packard. The team has evaluated policy, structure, and function at each health science campus which relates to monitoring and support of quality patient care and has made reports to each campus. The team has received action plans from each campus that has received a final report, and it has made follow-up visits to implement and modify those plans. The team has a consultative working relationship that has been friendly. The team's activities focus on reviewing and working with the campuses but also on developing cross-campus structures. It holds quarterly meetings with the medical director or chief medical officer of each medical campus to discuss common problems, identify best practices, and bring together activities that will promote interaction. The team has also developed Office of the President work groups that have pursued the development of policies, verified processes, and provided information, data, and support to the campuses to carry out their mission in this regard. Some campus and Office of the President relationships have been formalized to provide better interaction. Occasionally, the team has taken on specific projects for troubleshooting and consultation to campuses at their invitation, and new projects have been developed. The team has begun to examine dialysis center contracts and will expand that effort to examine contracts generally that relate to patient care and risk management practices.

Dr. Tupin noted that the team is working on a new definition of the scope of malpractice coverage for faculty and trainees. It is also working on a policy that will set standards for resident supervision throughout the system to provide confidence in faculty-resident interaction. Delegations of authority and governance at the medical centers are being examined to ensure that there are clear lines of authority and responsibility for accreditation, licensing, and high-quality patient care. The team has

been working with the Fresno program to set up adequate malpractice and risk management practices there.

Dr. Tupin reported that the team has established a collaborative effort with the Office of Risk Management at the Office of the President to develop a variety of data support analyses for the medical centers' policies and to emphasize the local responsibility in risk management and risk reduction. He noted that there is a local involvement in risk management, case analysis and claims analysis. That analysis enhances the quality improvement program at each medical center. Each campus has a committee, with members from administration in every health care profession, that works as part of the medical staff. These committees provide informed analyses of the claims that come forward and identify problems. The team is working with Vice President Broome to develop a stronger initiative than risk reduction and will report in the future about that issue.

Regent Johnson noted that the report emphasizes the local responsibility that the team is attempting to bring to each medical center. She asked what assurance there is that the campuses will make sincere efforts to tighten procedures. Dr. Tupin responded that the team is constructing an interactive model that recognizes the different levels of contribution to patient care. The risk management office has provided an analysis of the medical centers' claims experience and how those claims are being resolved. That information will be provided to the campuses to allow them to monitor their performance over time. It is being provided in a way to give the campuses opportunities to compare performances across the institutions. Dr. Tupin reported that he reviews claims that come to the Regents for approval and discusses with the medical centers ways of intervening to reduce risk. Although the University will always be confronted with claims, Dr. Tupin believed that its claims rate and its costs are lower than they are for many academic health centers. The team expects to bring a report on the financial and claims side of the issue to the Regents in the near future. The team will follow up on individual claims to make sure that the recommendations for improving the quality of care are implemented and risks to patients are reduced.

Regent Johnson asked whether the team could report to the Regents more often than annually. Vice President Gurtner believed that it would be reasonable to report quarterly. Dr. Tupin noted that one of the team's recommendations is to make its existence permanent.

6. **ACTIVITY AND FINANCIAL STATUS REPORT ON HOSPITALS AND CLINICS**

Vice President Gurtner noted that the activity and financial status report now includes data from UCSF Stanford Health Care.

The meeting adjourned at 11:15 a.m.

Attest:

Secretary

**RESOLUTION OF THE UNIVERSITY OF CALIFORNIA BOARD OF REGENTS:
HEALTH SCIENCES CLINICAL ENTERPRISE
CORPORATE COMPLIANCE PROGRAM**

As a leading provider of clinical services, education, and research, the University of California's (University) academic health centers should meet high standards for ethical and legal conduct. The University's quality, integrity, respect, and honesty in all activities has been the foundation for its success, and the University's future depends on maintaining and demonstrating a conscious dedication to the ethical and legal principles of the University's Health Sciences Clinical Enterprise Corporate Compliance Program (Program). This Program deals with conduct specific to the health sciences clinical enterprise in recognition of the increasingly complex and rapidly changing dynamic of today's health care environment and the need to support the University's employees in their commitment to ethical and legal conduct in all matters pertaining to the activities of the clinical enterprise. The University's clinical enterprise officers, directors, and individual employees should not take actions which undermine the University's tripartite mission and values or violate legal requirements.

It is unrealistic for any single employee to know every rule and regulation that exists for the clinical enterprise; however, each University employee should know the policies, laws, and procedures that apply to his or her job. The Program is just one of a number of resources available, and while the Program does not answer every question or concern, it will provide principles and standards of conduct that will guide employees in discerning the appropriate and correct action to take. It is important that every employee, regardless of position, follow the basic principles outlined in the University's Program and each academic health center's specific Health Sciences Clinical Enterprise Corporate Compliance Plan (Plan).

The University has always demonstrated through its mission, philosophy, and policies and procedures its commitment to ethical and legal behavior in all aspects of its academic, research, and service activities. All employees of the University's health sciences clinical enterprise have an obligation to act in a way that merits the trust, confidence, and respect of the public and other health care professionals. The Regents encourage all employees to engage in open discussion with peers and managers regarding both the principles of the Program and their campus-specific Plan, particularly when questions or concerns arise regarding what is the appropriate and legal standard. The University will not tolerate retaliation against any employee who, in good faith, reports an ethical or legal concern or raises questions regarding appropriate behavior.

The Board of Regents recognizes and appreciates the significant efforts of the members of the Universitywide Clinical Enterprise Corporate Compliance Committee in working with campus leadership and staff to develop the University's Program. The Regents congratulate all employees of the clinical enterprise for their demonstrated commitment to quality and ethical

behavior and support their ongoing efforts to enhance and maintain the University's meritorious reputation for preeminence in care, education, and research.