

The Regents of the University of California

COMMITTEE ON HEALTH SERVICES

November 18, 1999

The Committee on Health Services met on the above date at Covell Commons, Los Angeles campus.

Members present: Regents Atkinson, Davies, O. Johnson, Khachigian, Kozberg, Lansing, Leach, Montoya, Preuss, Sayles, and Vining; Advisory member Kohn

In attendance: Regents Hopkinson, S. Johnson, Lee, Moores, Pannor, Parsky, and Taylor, Faculty Representatives Coleman and Cowan, Secretary Trivette, General Counsel Holst, Treasurer Small, Provost King, Senior Vice President Kennedy, Vice Presidents Broome, Darling, Gomes, Gurtner, and Hershman, Chancellors Berdahl, Bishop, Carnesale, Cicerone, Dynes, Orbach, Tomlinson-Keasey, Vanderhoef, and Yang, Vice Chancellor Suduiko representing Chancellor Greenwood, and Recording Secretary Bryan

The meeting convened at 11:00 a.m. with Committee Chair Khachigian presiding.

1. **REMARKS OF VICE PRESIDENT DARLING CONCERNING MEDICARE FUNDING**

Vice President Darling reported that for the past year members of the administration have been working in Washington to address some negative impacts of the 1997 Balanced Budget Act on UC's teaching hospitals. Their goals have been to reduce the scheduled cuts in indirect medical education payments and to adjust an inequitable formula for funding medical residents. Last week the House, the Senate, and the White House agreed to roll back some of the reductions in Medicare payments to health care providers that were originally contained in the Balanced Budget Act. Reductions in indirect medical education reimbursements will be spread over a longer period of time and therefore lessen the cuts that UC will experience this federal fiscal year, and a gross inequity that has existed in funding medical residents will be lessened. The current formula, which was established in 1985, has benefitted New York and been hurtful to hospitals in California and 38 other states. Under the new agreement, hospitals that are reimbursed at less than 70 percent of the national average will be brought up to that 70th percentile, and hospitals that receive more than 140 percent of the national average will have their rate of growth slowed. The call for this change was led by Bakersfield Congressman Thomas, who chairs the Subcommittee on Health of the House Ways and Means Committee. Mr. Darling acknowledged Committee Chair Khachigian, who was instrumental in informing Mr. Thomas of the damaging effect of the Balanced Budget Act on the University's teaching hospitals. Her efforts were matched by those of UC administrators. Mr. Darling informed the Regents that their help in Washington on this issue will continue to be needed.

2. **APPROVAL OF REVISED PURCHASE PRICE FOR SALE OF DIALYSIS PROGRAM ASSETS TO GOLDEN GATE RENAL PARTNERS, SCHOOL OF MEDICINE, SAN FRANCISCO CAMPUS**

The President recommended that, in consultation with the General Counsel and the Vice President for Clinical Services Development, he be authorized to approve and execute documents necessary to effectuate a sale at a revised purchase price of the assets of the UCSF School of Medicine Renal Center located at San Francisco General Hospital to Golden Gate Renal Partners.

It was recalled that, at the March 1999 meeting, The Regents had approved the sale of the assets of the UCSF Renal Center, located at San Francisco General Hospital, to a new company called Golden Gate Renal Partners for a price of \$6 million. At that time Golden Gate Renal Partners informed UCSF that the documents to establish a joint venture between its parents, Satellite Dialysis Clinics Incorporated and Total Renal Care Incorporated, were in the final stages of development. However, operational issues within the two parent organizations delayed the formation of the joint venture until October 8, 1999. Given changes in the dialysis industry, Golden Gate Renal Partners has revised its purchase offer downward to \$4.65 million. The Department of Medicine has received notification from Golden Gate Renal Partners that this price is a firm price and is not subject to further negotiation. In addition, the Medical Director contract was reduced from \$120,000 to \$75,000.

Changes in the Dialysis Marketplace

In the months following approval granted by The Regents, there has been a substantial decline in the market value of dialysis facilities nationwide. This is evidenced by drops in the stock market prices throughout the dialysis industry. This market deterioration has resulted in a significant decrease in the acquisition prices being offered for dialysis units. When notified that Golden Gate Renal Partners was revising its purchase price, UCSF distributed a second Request for Proposal. The RFP was submitted to four nationwide dialysis firms; however, no additional bids to purchase the University of California Renal Center were received. The revised bid by Golden Gate Renal Partners at \$4.65 million was the highest offer made.

In spite of the lower purchase price, UCSF continues to believe that a sale of the dialysis unit is preferable to maintaining the operations, given the continuing decline in market conditions and future capital requirements that would be needed to support operations adequately.

Revised Summary of Transaction

Under the terms of the sale, Golden Gate Renal Partners will assume complete responsibility for all non-medical aspects of the UCSF Renal Center. Golden Gate Renal Partners will obtain a facility license, Medicare certification, and a facility

provider number. The transaction will involve the sale of certain assets, including equipment and inventory, and all other tangible and intangible assets to Golden Gate Renal Partners for a purchase price of \$4.65 million. As noted, the medical director contract will be \$75,000 per year. All other terms and conditions of the sale remain the same.

Environmental Review

The proposed transaction has been classified as categorically exempt under the provision of the California Environmental Quality Act.

Regent Leach asked for assurances that Golden Gate Renal Partners would consummate the agreement without delay. Dr. Talmadge King, Vice Chair of the Department of Medicine, reported that there is a definite agreement in place, subject to Regental approval.

Regent Montoya noted that concerns about the sale had been raised by UCSF Renal Center staff who believe that the merger between the non-profit Satellite Dialysis Clinics and the for-profit Total Renal Care would result in patients' being exposed to a potentially dangerous care setting. Dr. King disagreed with their opinions, which he believed were not supported by facts.

Regent Hopkinson asked about the sequence of events that led to the lower price. Dr. King explained that there was no contract in place when The Regents approved the sale originally; it is not possible to sign a contract before The Regents has voted on a sale. The delay in forming the joint venture between Satellite Dialysis and Total Renal Care was not anticipated. Between the time approval was received and a final contract was negotiated, the market changed dramatically. Ms. Mary Fishman, Director of the Department of Medicine, reported that the delay was caused by legal and technical issues related to accounting within a joint venture between a for-profit and a not-for-profit entity.

Regent Lansing stressed the importance of examining the issues of profit versus the quality of patient care and the meshing of different cultures. She asked whether Total Renal Care was a good fit with UCSF in those terms. Dr. King responded that the administration had worked hard to assure that issues of patient care and the ability of staff to function in the new environment would be monitored and that any problems that emerge would be rectified quickly. He noted that the choice of Satellite Dialysis Clinics, a member of the joint venture, was supported by the employees of the UCSF Renal Center. He emphasized that the Total Renal Care venture was thought to be the only bidder that would be financially viable in an industry where financial viability is very difficult to maintain. If a venture were not to break even, the ability to maintain good patient care would be compromised. In response to a further question by Regent Lansing, Dr. King stated that if he were to make a choice of partners based solely on maintaining high-quality care he would choose Golden Gate Renal Partners. Dr. Lee Goldman, Acting Vice Chancellor for Medical Affairs, believed that the sale will make

it possible to improve the current quality of care that the UCSF renal center provides to its patients.

Vice President Gurtner, recalling that the issues of maintaining high-quality patient care and meshing different cultures have been raised many times, emphasized that in this sale the University will retain medical direction of the unit. The arrangement is predicated on the University's reliance on Golden Gate Renal Partners to perform to a certain standard in a competitive market. The medical direction and participation of the University's doctors should provide sufficient leverage to defend against any potential problems. Also, the President's Clinical Policy Review Team will be following the progress of this venture and will include a review in its annual report to The Regents. He pointed out that these are the only protections the University has in arrangements of this type. The partner that was chosen has agreed to provide preferential hiring to qualified current employees of the UCSF renal care unit.

Regent Leach asked whether sufficient due diligence had been done in making a determination as to the culture and quality of care delivered at Golden Gate Renal Partners sites. Dr. King responded that he had discussed its reputation among other users and would be willing to visit individual sites. Ms. Fishman noted that the company will be jointly managed by Total Renal Care and Satellite and that all decisions will be by a supermajority of a governing board.

Regent S. Johnson stated that, although she was not entirely comfortable with the arrangement, she was pleased that the University will maintain rigorous oversight following the sale and that its doctors will be involved daily in assessing its practices. Dr. King noted that time and effort had been put into structuring a contract that stresses the importance of maintaining the quality of care and provides specific ways of testing whether that quality is being delivered consistently.

Dr. Goldman assured the Regents that the reason for this recommendation to sell the unit is that it is in the best interest of the University's patients. He believed that the unit can be run better by an experienced organization that focuses on dialysis. He believed that the best partner was chosen, that sufficient due diligence was performed, and that appropriate safeguards against any deterioration in quality were in place. In addition, The Regents, although it would continue to be liable for the performance of the doctors who use the facility, would no longer be liable in the event of deficiencies in the inadequate facility the medical center uses currently.

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

[For speakers' comments, refer to the minutes of the morning session of the Committee of the Whole.]

3. **UCI HEALTH SYSTEM PERFORMANCE IMPROVEMENT ANNUAL REPORT,
IRVINE CAMPUS**

It was recalled that, in the past four years, the combined UCI Medical Center and College of Medicine at Irvine has made significant changes in its operations and in its market strategy that have made it the leading specialty referral center in Orange County. Independent evaluations, such as the Joint Commission of Accreditation of Healthcare Organizations, patient care surveys, and employer group evaluations, such as that conducted annually by the Pacific Business Group on Health, have shown measurable improvements in key areas.

The campus is pleased with the performance of its medical enterprise, especially in light of very difficult market conditions and lingering challenges associated with the medical center's previous history as a County hospital. Like other medical centers and medical schools in UC and nationally, however, UCI faces two threats. First, the deteriorating state of the overall health care system has the potential to place UCI Medical Center in serious financial difficulty in the immediate future. In spite of its very low-cost structure and aggressive management, UCI is vulnerable to any one or combination of the following factors: continuation of Balanced Budget Act Medicare and Medicaid cuts, reduction in State disproportionate share hospital funds, unreimbursed increases in labor or drug costs, increased corporate compliance and regulatory expenses, mandated capital outlays to meet SB1953 or other requirements, or even a reintroduction of a UCRP pension contribution. The growing financial vulnerability of the medical center is a threat at UCI, as it is at most academic medical centers in California and at many across the nation. Second, at UCI and other centers nationally, there is a financial interdependence between the medical center and the medical school. Declines in the financial performance of the medical center directly or indirectly affect the teaching and research missions that are central to the University's reason for being in the health care delivery business. Concerns about the long-term viability of the historical financial model under which many medical centers and medical schools operate is a primary topic being discussed by leaders in the academic medical center community nationally.

Chancellor Cicerone recalled that in early 1998 the College of Medicine and the medical center started to work together on a joint strategic plan to maintain a high level of performance and increase quality, and in early 1999 the plan was described to the Regents. It recognizes that financial strength is the key to the clinical enterprise and its support for the academic medical program. The plan identified the need for a certain amount of growth and ways to position UCIMC as a referral center for certain specialties. Mr. Cicerone reported that there has been progress in research growth and success in recruiting faculty and chairs to the College of Medicine. Community support has also improved.

Director Laret provided details of the medical center's progress over the past four years. He recalled that he had been appointed director in 1995 and that Dean Cesario was also appointed that year. It was a difficult time. The Center for Reproductive Health had just closed, UCI's special supplemental payments for indigent care were cut by \$23 million, and Orange County introduced CalOPTIMA, a Medi-Cal HMO that

caused many of UCI's traditional patients to go to other doctors and hospitals. After months of being on the front pages of local papers, faculty and staff morale was very low. Dean Cesario, campus administrators, and Office of the President staff began work on multiple fronts, with an immediate focus on preserving the quality of care. UCI dramatically improved its score on its triennial accreditation survey from a low of 82 percent in 1994, with 12 areas for further review, to 98 percent in 1998, with one area for further review. Its score of 98 out of 100 was the highest among all academic medical centers surveyed. Another measure of quality is professional and hospital liability or malpractice costs and claims activity. In FY95, the average cost for UCI's claims was 17 percent higher than the average of all UC hospitals. As a result of intense and aggressive attention to this issue, the average cost per claim was reduced to one-third below the UC average. UCI's incidence of professional and hospital liability claims is less than one-half that of other UC schools. A third measure of quality is what patients say. A Pacific Business Group on Health survey of 70,000 Californians measured patient satisfaction with their medical group physicians. This year, among 29 southern California medical groups, UCI Medical Group was ranked by patients as the top physician group in patient satisfaction and perceived quality of care. Closely linked to quality medical care is providing good service. UCI's first patient satisfaction survey in 1995 showed that customer service was not good. Patients scored it in the bottom 5 percent of comparable institutions in terms of willingness to recommend it to friends. This year its score was in the top 40 percent. Its goal is to be in the top 20 percent by this spring. Employee morale was problematic. In a 1997 survey, UCI's employees rated it below the national average in well over half of the survey questions. This year employees ranked UCI higher on every question except one, that of its pay scale, and, compared to the national database, above the national average on three-quarters of the survey questions. They rated UCI significantly higher than the national average on having a climate of trust, a commitment to excellence, holding individuals accountable for being productive, and its quality of patient care.

Director Laret reported that patient volume fell every year from 1994 through 1997. UCI Medical Center was not generally viewed in the local medical community as being preferred by either patients or doctors. Since 1997, its inpatient volume has grown 18 percent, and outpatient visits have increased by over 20 percent. The hospital continues to provide care to far more county indigent and self-paid patients than any hospital in Orange County. Most new patient growth is the result of more Medicare and commercially insured patients' choosing to receive their care at UCI. UCI has become the referral center of choice for major medical groups in the county. Its international business also continues to grow.

Mr. Laret noted that UCI Medical Center has been profitable since 1996, when it lost nearly \$8 million as a result of cuts in its disproportionate share hospital payments. It finished 1999 with a gain of \$13.2 million on revenues of about \$225 million. The medical center continues to operate efficiently and to keep costs very low. Its already small workforce has been reduced by 10 percent during the past four years. It is expected that the medical center will end this fiscal year with a small bottom line and modest cash reserves.

Mr. Laret reported that research and education programs have also been blossoming. Commercial research funding has increased from \$49 million in 1996 to \$71 million this year. Faculty recruitment to clinical and basic science departments in the college of medicine has been successful, and philanthropic support is enabling the building of a second new research laboratory on campus. The campus' medical students operate an outreach and mentor program with high school students in Santa Ana. The over 40 residency programs meet the University's target for primary care trainees, and the medical school is doing well in national accrediting body surveys.

Mr. Laret emphasized that there are sobering circumstances afflicting academic medical centers across the country. The failure of UCSF Stanford Health Care is an example of how quickly a major financial setback can happen. The continuation of the Balanced Budget Act will result in multi-million-dollar cuts in UCI medical center revenue. Medical center labor costs rose over \$7 million this year as a result of a nursing shortage and normal salary increases. Those cost increases are well in excess of any payment increases likely from HMOs, Medi-Cal, and other payors. Potentially financially draining legislative directives on how hospitals must be staffed are under consideration. Academic medical centers are finding it necessary to hire corporate compliance staff to defend themselves against allegations of fraud, while those paying the bills, including the federal government, seem increasingly emboldened retroactively to redefine their financial obligations. Drug costs are skyrocketing, and in the current HMO structure hospitals are expected to absorb them. Many in the field view the HMO model as ultimately flawed and in need of major revision. Beyond the business implications of serious financial setbacks to academic medical centers, there are risks to medical schools. The decades-old financial model in which university hospitals have supported the cost of faculty recruitment, residency programs, and other academic initiatives is threatened. UCI Medical Center could face difficulty sustaining its reported progress. Mr. Laret observed that within this difficult environment, the University has a unique opportunity for leadership by virtue of its potent system of education and research. The UC system of medical schools and centers could be integrally involved in designing future health care in this country by taking a leadership role in Washington to shape the complex issues it faces. He believed that the time may be right to question historical assumptions about the optimum way to fulfill the University's clinical and academic missions and to consider looking for opportunities for greater collaboration and integration among the University's medical centers and schools. The central question is how to protect and enhance the academic strengths of the University's medical schools while reducing the risks of operating enormous clinical enterprises in increasingly uncertain times.

Regent Khachigian noted that the University's medical centers' high rates of occupancy not do translate to healthy profit margins because the reimbursements they receive are insufficient to meet their costs. President Atkinson agreed that, based on this fact, it may be appropriate to begin thinking of the University's medical schools and hospitals as a confederation. Vice President Gurtner noted that the topic is under discussion among the hospital directors, medical school deans, and chancellors.

4. UPDATE ON CLINICAL POLICY REVIEW

Dr. Joe Tupin, chair of the President's Clinical Policy Review Team, recalled that the team provides an annual assessment of the five medical centers in which it evaluates the policies that are in place in areas such as quality improvement, medical staff self-governance, and clinical risk management, and whether the campuses are taking advantage of best practices. He noted that the medical directors meet quarterly with the team to review a variety of policy and operational problems with a goal toward learning from each other and establishing systemwide standards of work.

Dr. Tupin reported that for the last six months the team has focused on risk reduction and its link to improvements in the quality of care. The team has met with the campus committees that review professional liability issues and has tried to draw from those reviews inferences for improvement in the quality of care and risk reduction. The team focused this year also on the dialysis contracts in place at the Davis and Los Angeles campuses, and Dr. Tupin indicated that it would add the new program at San Francisco to that review to ensure that the quality of care is maintained. He reported that recruitment has been undertaken for a full-time individual in a medical service director role at the Office of the President and that an appointment is expected early in the new year. He indicated his intention to remain as chair of the team for one more year to work with the appointee.

Finally, Dr. Tupin reported that the team is aware of concerns at a national level about human subjects research and the possibility for misadventure and is initiating a review of the University's responsibilities pertaining to the use of human subjects in research programs at each campus. It will also undertake an examination of the policies and practices pertinent to the University's willed body programs.

Regent Montoya asked whether the review of human subjects research would address public health matters. Dr. Tupin responded that the review would examine all areas where the University employs human subjects, including some related to public health research on campuses.

Regent-designate Kohn asked whether any best practices had been identified and put into place systemwide. Dr. Tupin noted as examples a web site designed by a UCLA physician that has an interactive model used for credentialing and privileging physicians and keeping records on their performance, and a claims review process involving faculty and administration for professional liability programs. These examples have established benchmarks, but their use has not been mandated, only strongly urged. When a best practice that has been developed by a campus has been identified, the team will ascertain whether it contains elements that would be appropriate for use by all campuses and may enlist the help of an advocate to explain to the medical directors how it works.

Regent Preuss agreed with Director Laret's observation that it may be time to view the University's five medical centers as a system. He asked whether there were theories as to how this could be beneficial. Dr. Tupin believed that there could be a number of

opportunities for identifying shared practices and best practices in patient care and related support activities that could prove also to be best business and educational practices. The team will continue its work to identify these.

Regent S. Johnson noted that the court cases and settlements involving the medical centers that are reported to The Regents by the General Counsel often appear to have been generated because procedures at the University's hospitals were not followed. She asked how often staff adherence to standard procedures is evaluated. Dr. Tupin responded that his team conducts a monthly review of all professional liability cases and attempts to extrapolate from each case lessons to be learned and opportunities to initiate improvement. The team is also involved in mandatory reviews of the individual profiles of all faculty physicians every two years using data sources that include risk management. Educational programs or other remedial action may be assigned in individual cases as a result of these reviews. Each institution also has an active in-service education program for nursing staff. The team ascertains whether the programs are being implemented continuously at all levels. Regent Bagley noted that litigation continues to escalate despite the administration's efforts to evaluate and educate its employees. He questioned the effectiveness of peer reviews. Dr. Tupin informed him that his team works closely with the General Counsel's Office to review individual cases and examine recurring trends. This effort will be enhanced by the recent hiring by the General Counsel of a staff person who will be responsible for the area of professional medical liability.

5. ACTIVITY AND FINANCIAL STATUS REPORT ON HOSPITALS AND CLINICS

Vice President Gurtner reviewed the financial results for the first quarter and urged all Regents to read them carefully. He noted that the administration's projections for the year were proving to be relatively accurate. Operating revenue increased by 1.5 percent, but expenses increased by 7.1 percent. Cash in reserves is minimal. He indicated that each campus is focused on responding to this problem and that in January he would provide details about their responses. The Davis and UCLA medical centers have specific staff reduction plans in place, and all five medical centers are focused on reducing costs.

Mr. Gurtner reported that the medical centers have begun to examine how they may improve their financial positions by operating as a system. He noted that, although there are many positive and rational reasons why the five centers have grown up independently, changes in the marketplace have caused profit margins to disappear. An evaluation is under way of the University's economic responsibilities as they affect the University's mission to educate students.

Regent Lee hoped that the University's experience with the UCSF-Stanford merger had provided some valuable lessons. Mr. Gurtner noted that as a result of the merger some practices became more successful and should be expanded throughout the system. More areas with similar potential need to be identified.

Regent Hopkinson asked why expenses increased so dramatically. Mr. Gurtner observed that the amount of increase differed among the sites. He indicated that he would elaborate at the January meeting on how each medical center was affected.

Regent Preuss recalled that in 1993 The Regents was informed by its external auditor that the University's medical centers faced heavy losses and an uncertain future. He asked that Mr. Gurtner report in January how the University had managed to avoid the most dire of the report's predictions.

6. **PROPOSED WINDING UP OF THE UCSF STANFORD MERGER**

The President recommended that The Regents:

- A. Approve the winding up of UCSF Stanford Health Care in accordance with procedures for unwinding the merger as described in Article IX of the Consolidation Agreement and terminate the various merger agreements including the Consolidation Agreement, the Assignment and Assumption Agreement, the Professional Services Agreements, the Affiliation Agreements, the leases, and the inter-entity agreements, in order to return management and operation of Moffitt Long Hospital, UCSF/Mount Zion, and associated clinical enterprises to UCSF under the governance of The Regents.
- B. Authorize the President, in consultation with the General Counsel, the Vice President of Clinical Services, and the Chancellor of UCSF, to execute all agreements and to take such steps as are necessary to carry out the procedures for winding up, including, but not limited to, the transfer of assets, liabilities, management, and appropriate workforce and financial operations of UCSF Stanford Health Care back to the respective Members.
- C. Authorize the President, in consultation with the General Counsel, the Vice President of Clinical Services, and the Chancellor of UCSF to either dissolve UCSF Stanford Health Care or to use the 501(c)(3) public benefit corporate structure for purposes of those joint activities or shared services which the Members may elect to retain at some future date and to execute those agreements necessary for carrying out those joint activities or shared services.
- D. Authorize the Treasurer to take such steps as (1) may be necessary for The Regents to become a replacement borrower for the 1998 Series A Bonds issued by California Health Financing Authority for the benefit of UCSF Stanford Health Care in accordance with the terms of the 1998 Series A Indenture; or (2) if The Regents are unable to become a replacement borrower in accordance with the terms of the 1998 Series A Indenture, to negotiate external financing not to exceed \$105 million to defease the 1998 Series A Bonds; subject to the following:

- (1) Repayment of any indebtedness assumed or negotiated shall be repaid from the gross revenues of the UCSF Medical Center.
- (2) The general credit of The Regents shall not be pledged.
- (3) The Officers of The Regents be authorized to execute all documents and agreements as may be necessary in connection with the above.
- (4) Require regular reporting to the Board of Regents by the General Counsel, the Chancellor of UCSF, and the Vice President of Clinical Services regarding the status of those activities necessary to achieve a timely unwinding of the merger.

It was recalled that in November 1997, The Regents approved the merger of the clinical activities of the Medical Center at the University of California, San Francisco (UCSF) and Stanford Health Services (SHS) to form UCSF Stanford Health Care, a private nonprofit public benefit corporation intended to strengthen the long-term prospects of the hospital, clinic, and faculty practice operations of UCSF and SHS and provide enhanced support for the academic missions of the two medical schools.

On October 28, 1999, President Gerhard Casper of Stanford University advised President Richard Atkinson that he was requesting that "...we begin the process of unwinding the current venture," stating a number of reasons for his request, including the following:

- (1) A failure to achieve a common UCSF Stanford Health Care culture.
- (2) A failure to integrate fully the medical centers and faculty practice plans.
- (3) Transaction costs greater than projected in the business plan.
- (4) A unitary management structure that did not provide the flexibility and resources needed for managing the north and south sites effectively.
- (5) The negative impact of the Balanced Budget Act of 1997 that exceeded projections.

Rationale for Winding Up UCSF Stanford Health Care

Without the full cooperation and participation of both Members, the University believes that UCSF Stanford Health Care will not achieve the academic and clinical benefits envisioned. Under these circumstances, the President recommends that The Regents adopt a resolution to support the winding up of the corporation.

The Corporations Code of the State of California provides that a nonprofit public benefit corporation, such as UCSF Stanford Health Care, may elect to wind up and dissolve by:

- (1) Approval of the majority of its members; or
- (2) Approval by its board (the UCSF Stanford Health Care Board) and approval of its members (The Regents and Stanford Trustees).

As noted, President Casper's letter of October 28, 1999 refers to the winding up of the corporation, with no reference to voluntary or involuntary dissolution, nor have the Stanford Trustees adopted a resolution calling for dissolution of the corporation. The distinction between winding up and dissolution is that winding up may occur with management and financial responsibility being returned to UCSF and Stanford respectively, but the corporate structure is not yet dissolved, for a variety of reasons. For example, the corporation may still have to liquidate liabilities even though the transfer of management and financial responsibility to UCSF and SHS for hospital operations can be accomplished sooner. In addition, the fact that the corporation has not been dissolved means that the 501(c)(3) nonprofit public benefit corporation may be used for another purpose, such as a corporate structure for the sharing of services by UCSF and SHS.

Prior to President Casper's proposal to wind up the corporation, leadership from the Office of the President had been working closely with Stanford University representatives to reassess the merger and respond to the requests of both Presidents that their respective staffs provide recommendations for the future direction of the merger. The October Report to the President identifies several integrated functions that have resulted from the merger of UCSF and SHS and that have provided added value to the Members that would not have occurred without the merger, including children's services, information technology, home health care, and laboratory services. Should the Members determine at some future date that there are significant benefits to continuing one or more of these activities, the corporate structure could be maintained to provide for those activities.

Process for Winding Up and Dissolution as Agreed to by the University of California and Stanford University

The winding up and dissolution process commences when resolutions are adopted by both Members. It is the University's view that the process should be the same for winding up and for dissolution. When the Regents approved the merger, they reserved to themselves the power to vote on any matter that was a reserved power under the bylaws of UCSF Stanford Health Care. One such reserved power is the authority to approve the winding up and dissolution.

The UCSF Stanford Board will continue to have full powers over the corporation's affairs until wind up and/or dissolution is complete. The corporation may conduct those activities necessary for orderly winding up of its functions.

Paragraph 9.2.2 of the Consolidation Agreement is a template on how the parties would deal with assets and liabilities in the event of winding up and/or dissolution. It provides that the starting point is the value of net assets brought to the opening balance sheet of UCSF Stanford Health Care, adjusted for increases or decreases in the equity on the part of each Member. Upon either winding up or dissolution, there will be an accounting or an audit of the net assets so that each Member's proportional interest can be determined. Each Member will receive back the real property and facilities it has leased to UCSF Stanford Health Care. Assets acquired after the effective date of the merger that are located in or on the real property of each Member will be returned to that Member. Profits and losses from operations will be shared on a 50-50 basis. A Member assuming contracts, provider agreements, leases, and programs will assume the liabilities associated with those arrangements. Workforce-related liabilities will be assumed by the Member offering employment to employees associated with those liabilities. To the extent that assets are not designated, they will be allocated functionally so that programs and services that rely on the assets will be conveyed to that Member whose use will enable the Member to continue its operations. These will be matters of further discussion as the process of winding up unfolds.

Decision to Dissolve the Corporation

Should the Members determine at some future date that there is no reason to retain the 501 (c)(3) corporate structure of UCSF Stanford Health Care, the process to dissolve UCSF Stanford Health Care would include all actions taken in order to wind up the corporation, as well as the formal steps to dissolve the corporation as required by the Secretary of State.

Assumption of Debt

In March 1998, California Health Facilities Financing Authority issued \$106.1 million in 1998 Series A Bonds and \$193.9 million in 1998 Series B Bonds for the benefit of UCSF Stanford Health Care. Proceeds of the 1998 Series A Bonds were applied to projects at UCSF, and proceeds of Series B Bonds were applied to SHS. Approximately \$104.7 million of 1998 Series A Bonds are outstanding.

During August 1999, Moody's Investors Service and Standard & Poor's Rating Agency downgraded the underlying ratings assigned to UCSF Stanford Health Care. Additionally, both the level of interest rates and the market premium for health care bonds have increased. Therefore, it would be impossible to duplicate the 5 percent interest rates achieved at the time the 1998 Series A Bonds were issued, and it would be advantageous for The Regents to assume the 1998 Series A Bonds in accordance with the terms of the 1998 Series A Indenture, if possible.

In order to assume the 1998 Series A Bonds, UCSF must meet certain financial ratios. The University Treasurer's Office will be in discussion with the municipal bond insurers which provided bond insurance on the 1998 Series A Bonds and the rating agencies concerning these financial ratios. The UCSF Stanford Health Care FY 99 audit and the UCSF business plan to be developed for fiscal year ending June 30, 2001 will be used to determine these ratios. If UCSF cannot meet the financial tests required for debt assumption or obtain the waivers from the bond insurers for compliance with those tests, the Treasurer will negotiate external financing to defease the 1998 Series A Bonds at the time the Consolidation Agreement is terminated.

Anticipated Time Line For Winding Up

There are a number of matters that need to be addressed during the winding up process. Section 9.2.2 of the UCSF Stanford Health Care Consolidation Agreement clearly provides that an audit needs to be conducted once a date is established for the transfer of assets and liabilities back to both Members.

The Members will work with the USHC Board to establish a time line for winding up and/or dissolution that will take into account the following issues:

- (1) Identifying employees to be offered employment by the Members.
- (2) Separating the USHC pension plans.
- (3) Obtaining hospital and other necessary licenses to operate.
- (4) Obtaining Medicare certification.
- (5) Assigning agreements, including agreements for services and supplies as well as payor agreements.
- (6) Obtaining provider numbers.
- (7) Obtaining necessary accreditations.
- (8) Addressing the tax consequences of the transaction.
- (9) Obtaining consents from administrative agencies.
- (10) Addressing the debt issued by California Health Facilities Financing Authority.
- (11) Addressing contingent liabilities including litigation and claims against USHC.

It is to the advantage of both Members, to faculty and non-faculty employees, and to patients for both Members and UCSF Stanford Health Care to identify as soon as possible a realistic time line so that the unwinding is handled expeditiously. March 1,

2000 has been proposed as the earliest possible date, but the Members and UCSF Stanford Health Care Board will not be able to establish a time line until early December 1999.

Vice President Gurtner reported that he has appointed a negotiating team that includes Deputy General Counsel Lundberg and Senior Vice President Kennedy. The primary work is being undertaken by the campus, with the help of consultants as necessary.

Chancellor Bishop described how UCSF is approaching the winding up and pursuing the recovery plan. He indicated that in the reassimilation of the medical center, transaction costs will be substantial. Mr. John Stone, of The Hunter Group, who presently is chief operating officer, is leading the reconstitution of the hospitals' management. Many crucial management positions have been filled already, and the search for a permanent director is under way. The medical center's recovery plan envisions breaking even by 2001 and becoming profitable the following year. Reconfiguring the Mt. Zion and Parnassus hospitals will result in the closure of the inpatient and emergency services at Mt. Zion.

Chancellor Bishop stressed that the operating losses of UCSF's hospitals do not threaten the fiscal integrity of its various schools. The School of Medicine, which is the most affected, receives only about 6 percent of its total budget from hospital income. The medical center and campus are separate fiscal entities. He stressed also that the problems caused by the merger have not affected the medical center adversely in terms of extramural funding of research, philanthropic giving, quality of students, laurels for faculty, recruitment of new faculty, or any other measure of quality. In those terms, UCSF Medical Center remains one of the best in the world.

Regent Pannor asked how the assumption of debt will be allocated. Mr. Gurtner explained that starting and ending equity points are based on a complex formula. In simple terms, the losses of the organization on the date of dissolution will be shared equally by the partners.

Regent Pannor asked whether the expense of employing The Hunter Group was justified. Mr. Gurtner believed that the University did not have the in-house expertise required to recover from such a serious crisis. The Hunter Group is expert at making organizations sufficiently stable to enable non-crisis issues to be addressed.

Regent Pannor noted that the Regents have stated clearly that the quality of patient care is of primary importance to them. In light of that opinion, she wondered how the closing of the Mt. Zion Hospital could be justified. Mr. Gurtner responded that, although the decision to close the hospital was financial, it was clear that a hospital cannot deliver high-quality patient care if it has a census that is inadequate to sustain its laboratories and intensive care units.

Regent Leach believed that the merger was supported substantially by faculty at UCSF but did not enjoy the same level of faculty support at Stanford. He hoped that there would continue to be some clinical cooperation between the two faculties.

Chairman Davies believed that dissolving the merger would put the UCSF Medical Center in a less advantageous position in the marketplace. He urged the Regents to resist trying to analyze the details of the current negotiations and instead voice their opinions at the conclusion of the process. General Counsel Holst noted that The Regents is represented on the UCSF Stanford Board of Trustees and that any action that is taken will require Regental approval.

Regent Lee believed that the merger was a good idea when it was approved and that it continues to be a good idea. He hoped that, since the determination had been made that it should be dissolved, the winding up would proceed quickly. He was confident that the experience of having gone through the merger process would make it easier to envision and implement ways in which all the University's medical centers could begin working together.

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

[For speakers' comments, refer to the minutes of the morning session of the Committee of the Whole.]

The meeting adjourned at 1:15 p.m.

Attest:

Secretary