

The Regents of the University of California

COMMITTEE ON HEALTH SERVICES

March 17, 2011

The Committee on Health Services met on the above date at UCSF–Mission Bay Community Center, San Francisco.

Members present: Regents De La Peña, Island, Johnson, Lansing, Pattiz, Ruiz, Schilling, and Zettel; Ex officio members Gould and Yudof; Advisory members Anderson, Mireles, and Pelliccioni; Staff Advisors Herbert and Martinez

In attendance: Regents Blum, Crane, Hime, Makarechian, Reiss, and Varner, Regent-designate Hallett, Faculty Representative Simmons, Secretary and Chief of Staff Griffiths, Associate Secretary Shaw, General Counsel Robinson, Chief Investment Officer Berggren, Chief Compliance and Audit Officer Vacca, Provost Pitts, Executive Vice Presidents Brostrom and Taylor, Senior Vice Presidents Dooley and Stobo, Vice Presidents Beckwith, Darling, Lenz, and Sakaki, Chancellors Block, Blumenthal, Desmond-Hellmann, Drake, Fox, Kang, Katehi, White, and Yang, and Recording Secretary McCarthy

The meeting convened at 10:15 a.m. with Committee Chair Lansing presiding.

1. APPROVAL OF MINUTES OF PREVIOUS MEETING

Upon motion duly made and seconded, the minutes of the meeting of September 15, 2010 were approved.

2. UPDATE ON HEALTH CARE REFORM AND ITS IMPACT ON THE UNIVERSITY OF CALIFORNIA

[Background material was mailed to Regents in advance of the meeting, and a copy is on file in the Office of the Secretary and Chief of Staff.]

Senior Vice President Stobo stated that health care reform would be evolving over the upcoming several years. He emphasized the special relationship between UC's medical centers and its professional medical schools, and noted that the effects of health care reform on one part of the system cannot be viewed in isolation. The medical centers and the professional medical schools are inexorably linked in a beneficial way. Dr. Stobo expressed his opinion that health care reform would occur irrespective of events in Washington or in the courts. The major driver of health care reform would be budget pressures from the cost of health care.

Dr. Stobo maintained that UC's world-class medical centers could not exist without its outstanding health professional schools. Recent poll results from *U.S. News and World*

Report ranked UC's five medical schools in the top 50 in the nation, with three in the top 15; UCSF's School of Nursing was ranked fourth; UCSF's School of Pharmacy was ranked first; UC Davis' School of Veterinary Medicine was ranked second; and UC's two public health schools were ranked among the nation's top ten. Dr. Stobo noted that his comments would be confined to the medical schools, although UC's nursing, pharmacy, dental, and public health schools are also critically important.

Dr. Stobo reported that 2010 patient revenue from UC's medical centers was almost \$6 billion; medical school revenue was \$3.8 billion. Thus, their combined revenue was almost \$10 billion, or roughly half of the total UC budget. The medical centers and medical schools receive relatively little financial support from the State, with that amount decreasing each year. Medical centers received 0.3 percent of their revenue from the State in the form of clinical teaching supplements; UC's medical schools received seven percent of their funding from the State.

Dr. Stobo stated that there is a critically important transfer of funds from UC's medical centers to UC's health professional schools, primarily the schools of medicine. In 2010, \$428 million was transferred from the medical centers to UC's medical schools, roughly half of that amount in the form of purchased services. For example, a UC medical center would pay for a medical director in a school of medicine to perform a function in association with the hospital, or the medical center would pay for teaching programs, or for technology infrastructure. The other half, or \$228 million, was cash transferred from the medical centers to the schools of medicine to support programs that advanced both the schools of medicine and the medical centers. Over the past seven years, the amounts of such cash transfer to support UC's schools of medicine ranged from a low of 30 percent to a high of 60 percent of the operating margins of the medical centers. Year after year, UC's medical centers have transferred money, in purchased services and in cash, to UC's schools of medicine; this mutually beneficial arrangement has allowed both the medical centers and the medical schools to function at the highest levels.

Dr. Stobo reiterated his view that health care reform would occur, irrespective of the fate of the Patient Protection and Affordable Care Act (PPACA) President Obama signed in March, for three reasons. First, rising health care costs in the United States are unsustainable, with annual double-digit increases over the past several years. Health care costs are currently 16 percent of the gross domestic product (GDP), twice that of the next highest nation, and the highest per capita health care cost in the world. Second, these high costs are not resulting in better health care. In measures such as longevity and neo-natal mortality, the United States ranks in the lower quartile or middle of 30 developed nations in terms of outcomes and quality of care. Third, the national debt, currently 62 percent of GDP, is unsustainable.

Dr. Stobo expressed his opinion that President Obama's National Commission on Fiscal Responsibility and Reform's proposals would be a blueprint for future deficit reduction. The proposals outlined plans for a reduction of more than \$400 billion in health care spending over eight years, with recommended cuts in Medicare and Medicaid spending, and block grants, among others.

Dr. Stobo reported that the effects of health care reform are already being felt at UC Health. To address issues of cost, payers are examining quality and safety issues. Dr. Stobo explained that UC's Medicaid hospital waiver, renewed the past fall for another five years, essentially federalizes UC's Medicaid payments. UC Health receives 75 percent of its Medicaid payments from the federal government, not the State, which offers some protection from State cutbacks to its Medicaid program. In the current year, any incremental Medicaid payments will have to be earned; the base rate for Medicaid payment will be increased only if certain goals are achieved, such as managing chronic diseases, reducing readmission rates, using technology to advance the quality of health care and access to health care, reducing hospital-acquired infections, and other issues around safety. Of the \$770 million that UC receives through the waiver, over \$100 million comes from this incentive pool. As a result, all of UC's hospitals and medical schools have submitted five-year proposals addressing issues of safety, efficacy, outcome-based health care, and value-added health care, to the State and the Centers for Medicare and Medicaid Services (CMS) for approval.

Similarly, Medicare is moving toward value-based purchasing, under which it will pay only for items that fulfill its quality targets, and will not pay for items that are unnecessary or undesirable. Thus, both Medicaid and Medicare will address issues of quality and cost by setting high standards for delivery of health care. CMS also has a four-year plan for the use of technology in electronic health records. All physician groups and hospitals must "meaningfully use" this technology to address health care issues. UC Health is in the implementation process.

Dr. Stobo noted that UC Health negotiates premiums with each commercial insurer for all five of its medical centers at the same time; any contract must include all five medical centers. In addition, each commercial insurer starts and ends its contract at all five medical centers at the same time. Dr. Stobo stated that he would like to have contracts in place with all UC Health's commercial insurers by January 2014 when the health insurance cooperatives outlined in the PPACA are scheduled to come into being.

Dr. Stobo commented that, over the past several years during negotiations with commercial insurers over reimbursement rates, the emphasis has moved to include issues of access and quality. For instance, commercial insurers want to know what UC is doing to reduce rates of readmission and hospital-acquired infections. UC Health is working with other hospital systems to share data, discuss best practices, and learn from one another.

The UC Center for Health Quality and Innovation, capitalized by the medical centers, has been created to provide funding for individual campuses' projects that could be applied systemwide addressing issues of quality and coordination of care. A Request for Proposal (RFP) was issued a few weeks prior; responses should be obtained in May and the first projects funded in July. Dr. Stobo noted that the University can bring tremendous intellectual power to support innovation in these areas.

Dr. Stobo stated that UC Health has already started to collect data on quality issues. For example, Dr. Stobo displayed a bar graph illustrating 30-day readmission rates to the same hospital for a related condition at UC's five medical centers. He cautioned that this data was not adjusted for severity of illness; some medical centers see generally sicker patients than others. Another bar graph depicted data on inpatient heart attack mortality rates at the five centers. Again, this data can be related to severity of illness. A third bar graph depicted patient satisfaction as the percentage of patients who would definitely recommend the hospital. Dr. Stobo stated that UC Health is collecting data, which it will use to approach issues of quality of care, on eleven such parameters; others will use such data to determine whether UC will be compensated for its work.

Dr. Stobo displayed a chart illustrating the medical centers' progress in implementing electronic health records. CMS has a four-year plan for the use of technology, through which providers must address "meaningful use" of electronic health records, in other words, show that they meaningfully use this technology to address health care issues. This process, divided into three stages, involves both medical centers and physician groups; implementation began in the current year and is slated for completion by 2015. Dr. Stobo noted that this implementation is not easy, since it depends on both advances in technology and changes in behavior and culture. Medicare or Medicaid payments can be received as incentives as each stage is completed. Should the program not be implemented by 2015, the positive incentives expire and a negative incentive of lower payment reimbursement begins. Electronic health records will make health information much more accessible and transportable, decreasing cost by eliminating redundant testing.

Dr. Stobo summarized his presentation by reiterating that health care reform will occur and will affect both the medical centers and the professional health schools because of their interrelationship. There will be a financial impact to the medical centers through the individuals paying for care through Medicare, Medicaid, or commercial insurers, and to the medical schools as, for instance, the National Institutes of Health (NIH) budget is reduced. Dr. Stobo expressed his opinion that UC is well-poised to address these issues. He noted that some of the major financial challenges to the medical centers are from internal sources, such as contributions to the UC Retirement Plan (UCRP) requiring significant commitments from the operating margins.

Committee Chair Lansing stated that the Committee appreciates the leadership of Dr. Stobo, and the heads of the medical centers and professional schools. She recalled a time when the Board was very concerned because the medical centers were losing money, even though the Board was convinced that the work of the medical centers was a core part of UC's mission. Increased collaboration among UC's medical centers has resulted in higher functioning throughout UC Health. Committee Chair Lansing commented that such collaboration could serve as a model for the whole UC system.

Committee Chair Lansing expressed her opinion that the University of California can be a leader in changes in health care. For example, the Ronald Reagan UCLA Medical Center is piloting a program using best practices to reduce the number of hospital-

acquired infections. Such pilot programs could lead the UC system and the nation. UC Health is also examining innovative ways to generate revenue through UC's patents. She thanked Regent De La Peña, members of the Committee and the advisory committee, Dr. Stobo, his team, the medical school deans, and the leadership of the medical centers.

Regent De La Peña complimented Dr. Stobo on his negotiating team, which has been very successful in negotiating rates for services. He noted the importance of flexibility in the changing health care arena, and agreed with Dr. Stobo on the importance of securing rates for 2014.

Dr. Stobo expressed appreciation for the work of Associate Vice President Santiago Muñoz in negotiating contracts for the five medical centers. Dr. Stobo pointed out that UC gains tremendous leverage by negotiating for the five medical centers together. The total strength of the UC health system far exceeds the sum of the individual medical centers. He also noted the positive, mutually beneficial collaboration among the medical centers.

Regent Makarechian asked about the amount of charity care provided by UC medical centers, through services they provide, but for which they are not reimbursed. Dr. Stobo stated that, while he is unsure of the exact amount, UC Health performs significant charity work, to differing degrees at the various medical centers. He noted that, under the PPACA, 33 million more Americans should have health care coverage. However, this increase in coverage will be counterbalanced by decreases in payments from other sources, and Dr. Stobo stated that the financial outcome is currently unclear. At the present time, the number of uninsured is increasing and represents a major challenge to UC Health.

Regent Makarechian asked if UC Health has contracts for the provision of charitable work. Dr. Stobo responded that some medical centers have contracts with their local communities for their charity work; however, in the current financial environment, the community entities have often been unable to deliver payment. Other UC medical centers provide services to the uninsured with no contracts in place. All hospitals are bound by regulation to treat emergency room patients, irrespective of the insurance status of the patient.

Regent Makarechian asked if there is a way to limit malpractice exposure related to treatment of uninsured patients. Dr. Stobo replied that such limits would be difficult from both a logistical and an ethical standpoint. He stated that UC Health attempts to determine whether uninsured patients may be eligible for other programs such as Medicaid. In addition, the medical centers try to establish follow-up care in the community so that patients do not have to return to the emergency room. The cost of a visit to the emergency room can be two or three times the cost of a visit to a medical clinic. UC's medical centers are devising ways to ensure that both insured and uninsured patients have a coordinated care plan when they leave the emergency room so they can receive care on an outpatient basis. Dr. Stobo stated that the University cannot limit its

liability in cases in which it is providing charitable services to uninsured patients for which it is not receiving payment.

Committee Chair Lansing noted that UC medical centers do not refuse service to anyone and treat the sickest patients, as this is part of UC's mission. She noted an area of opportunity in follow-up care.

Regent-designate Pelliccioni asked Dr. Stobo if a corrective plan is in place to improve quality metrics. Dr. Stobo noted that the data had not been adjusted for severity of illness and that medical centers are already working on creative and exciting ways to improve outcomes in, for example, 30-day readmission rates. Dr. Stobo stated that UC Health would not be paid \$110 million under the Medicaid incentive plan in the current year if quality targets are not met.

Regent-designate Pelliccioni asked what internal controls are in place to ensure proper implementation of electronic health records. Dr. Stobo responded that the chief information officers of the medical centers meet on a regular basis to share best practices and implementation problems. Four of the medical centers use the same vendor for electronic health records; the fifth center already had made good progress and did not need to change vendors. The chief information officers discuss which parts of the "meaningful use" of electronic health records they have chosen to implement. Dr. Stobo noted that 25 targets must be implemented in the current year. Again, the UC health system benefits from the collaboration among the medical centers. Regent-designate Pelliccioni asked if the implementation was being audited and tested as it progresses. Dr. Stobo stated that payments would come through Medicare and implementation would be auditable through the Medicare program.

Regent Varner thanked Committee Chair Lansing and Regent De La Peña for their leadership. Regent Varner asked for information on the amount of public service that UC Health provides through the unreimbursed health care services it provides. This figure would be relevant to discussions about compensation of executives in the health care system. He noted that the abilities of the executives leading UC Health enable the system to provide such valuable services to the people of the state.

Regent Johnson asked if electronic health records could eliminate the need for a patient to repeat medical tests at various UC facilities. Dr. Stobo responded in the affirmative, adding that some UC health centers had started to implement electronic health records before they were mandated by CMS. He noted that use of electronic health records would address issues of correct medications, transportability, and individual access to one's own medical records. Dr. Stobo commented that electronic records would also enable UC Health to access records of a much larger patient base across its system so that best practices could be determined and implemented. Electronic records would be transportable both within the various departments of one medical center and also among different hospitals. In response to a question from Committee Chair Lansing, Dr. Stobo estimated that the system would be ready to enable sharing of records among hospitals by 2015.

Staff Advisor Herbert reported great staff excitement around innovations in UC Health. Ms. Herbert asked about the staff resources that will be necessary for compliance with reporting requirements under the new health care regulations. She noted that these staff responsibilities could affect the medical centers' ability to maintain adequate bedside staff. Dr. Stobo reported that at all five UC campuses with medical centers, all new employees receive Health Insurance Portability and Accountability Act (HIPAA) training, and all faculty and employees receive HIPAA training annually.

Regent Blum commented that UCSF is well-known in the Bay Area for taking care of the most seriously ill patients. He asked if having a high number of extremely ill patients works against UCSF's statistics. Dr. Stobo agreed that UCSF cares for many extremely ill patients and treats many patients transferred from other hospitals. Statistically, Dr. Stobo reported that patients seen at UCSF are nearly twice as sick as those seen at community hospitals. Committee Chair Lansing cited the example of a report on length of hospital stay in which UCSF had longer stays, due to the fact that patients were more ill when they came to the hospital. She stated that this differentiation should be made in the reporting statistics.

Regent Blum asked for Dr. Stobo's estimate of how much revenue to UC Health would be reduced through cost-cutting by the federal and State government, in NIH grants, Medicaid, or Medicare. Dr. Stobo stated that the proposed Medicaid cut is ten percent. He stated that the picture is complicated since much of UC Health's Medicaid revenues come through CMS and, as a result of the Medicaid hospital waiver, UC Health receives a slight beneficial adjustment in Medicaid rates. In addition, negotiations are ongoing at the State level. He stated that the effect of these cuts should become more apparent by the following month. The base level of NIH grants would be rolled back to 2003 levels, with subsequent annual increases equal to the rate of biomedical inflation. In response to a question from Regent Blum, Dr. Stobo indicated the NIH reductions would result in an approximately ten percent cut to UC Health. The Medicare program that supports training of residents would be cut \$100 million per year for five years under the formula proposed by the National Commission on Fiscal Responsibility and Reform.

Commenting upon Regent Varner's earlier question, Regent Blum estimated that the amount of treatment UCSF provided for patients unable to pay totaled \$150 million for the year. Regent Blum asked Dr. Stobo to project what savings could result from implementation of electronic health records by 2015. Dr. Stobo responded that opinions vary as to the savings, with some saying the savings will be significant, others saying there will be only small savings, but much better services for patients.

Regent Zettel asked whether the statistics in Dr. Stobo's presentation slides were all benchmarks for the incentive program. Dr. Stobo responded that some of the statistics, such as rates of 30-day readmission and hospital-acquired infections, were mandated by CMS in order to be eligible for the incentive pool.

Regent Zettel asked about the RFP for the UC Center for Health Quality and Innovation. Dr. Stobo stated that the RFP concerned two areas. One area is to develop a quality

metric that is an improvement over a hospital's 30-day readmission rate. The other would provide funding for finding transportable methods of reducing hospital-acquired infections.

Regent Zettel asked about economies of scale that could be achieved by centralizing payroll systems or patient billing systems. Dr. Stobo responded that UC Health is in the initial stages of improving systemwide patient billing procedures. He noted that two medical centers are considering combining their patient billing systems and agreed that savings could be achieved this way.

President Yudof noted that half the revenues of the University are from its medical enterprises. UC is as much in the business of providing medical care and research as it is in the business of teaching humanities and other subjects. President Yudof pointed out that the vast bulk of incentive pay for performance at UC's medical centers goes to 22,000 employees at all levels, including unionized employees, physicians, and nurses. Only 0.3 percent of medical center income is from State funding. UC medical centers must be competitive with other providers of medical care, with competitive compensation, facilities, and caliber of services provided to patients. Only seven percent of the medical schools' income is from State funding, and two percent from tuition.

President Yudof stated that the outcomes desired by Medicare are built into UC's incentive programs. The very items that will enable UC Health to qualify for incentive funds from the federal government are part of UC's incentive structure. UC is attempting to incentivize physicians and others to accomplish those things that will entitle UC to more compensation from the federal government.

Committee Chair Lansing emphasized the importance of President Yudof's prior comment. She stated that a great deal of work has been accomplished by Dr. Stobo and his leadership team to incorporate incentives and accountability into compensation.

Regent Ruiz commented on the large amount of money donated to UC's medical centers and expressed his opinion that these contributions are due to the quality of care UC Health provides to the public. There is enormous value to the state and its residents in the services provided by UC Health. Committee Chair Lansing confirmed that surveys have shown that the vast majority of donors are grateful former patients, their families, and friends.

The meeting adjourned at 11:10 a.m.

Attest:

Secretary and Chief of Staff