

The Regents of the University of California

COMMITTEE ON HEALTH SERVICES

March 27, 2012

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

Members present: Regents De La Peña, Makarechian, Mireles, Pattiz, Pelliccioni, and Zettel; Advisory member Anderson; Staff Advisor Herbert

In attendance: Regent Newsom, Regent-designate Stein, Faculty Representative Powell, Secretary and Chief of Staff Kelman, Associate Secretary Shaw, General Counsel Robinson, Senior Vice President Stobo, Chancellor Katehi, and Recording Secretary McCarthy

The meeting convened at 3:00 p.m. with Committee Chair De La Peña presiding.

1. PUBLIC COMMENT

Committee Chair De La Peña explained that the public comment period permitted members of the public an opportunity to address University-related matters. The following persons addressed the Committee:

- A. Ms. Michelle Greenwood, UC Merced graduate student, chair of the Council on Student Fees, and chair of the UCM Student Fee Advisory Committee, thanked the Committee for the changes that are being made in the credentialing of professionals at the student health centers. She expressed concern about the potential for increases in student fees that fund the health centers or in student health care premiums. She stated that issues involving student fees should be addressed by the Council on Student Fees. Ms. Greenwood also noted her opposition to any further tuition increases.
- B. Ms. Bahar Navab, president of the Graduate Assembly at UC Berkeley and the graduate chair of the Council of Presidents, expressed her appreciation for actions being taken regarding the student health and counseling centers in order to deliver the best health services possible to students. However, she stated that students are concerned about the financial model, and advocated for including students and the directors of the health and counseling centers in any discussions of financial modeling. She encouraged the University to make a guarantee to students that any changes in the financing of the student health and counseling centers would not have a negative effect on student fees or existing student services.
- C. Mr. Victor Quintanar, UC Irvine graduate student, thanked the Board for acknowledging students' concerns about issues regarding privacy and student fees in the changes to the student health and counseling centers. He expressed

appreciation for the inclusion of students in discussions about the student health centers. He stated that, since poll results show significant support for public higher education, the Governor's tax initiative would have a better chance of passage if it specified funding for higher education. Mr. Quintanar also urged support for the Middle Class Scholarship Act.

2. **APPROVAL OF MINUTES OF PREVIOUS MEETING**

Upon motion duly made and seconded, the minutes of the meeting of January 18, 2012 were approved.

3. **UC HEALTH: HEALTH CARE REFORM, THE FEDERAL DEFICIT, AND UNIVERSITY OF CALIFORNIA RETIREMENT PLAN CONTRIBUTIONS – THE PERFECT STORM**

[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.]

Committee Chair De La Peña stated that this discussion would focus on the challenges facing UC Health in the upcoming few years, caused by federal budget cuts, health care reform, and employer contributions to the UC Retirement Plan (UCRP). He expressed his view that UC Health is well-positioned to address these challenges.

Senior Vice President Stobo updated the Committee on progress regarding the student health and counseling centers. He reported that on-site visits to all ten campus student health and counseling centers by independent consultant Marsh USA, Inc. (Marsh), other staff from the Office of the President, and often Dr. Stobo and Committee Chair De La Peña, had been completed by the end of the past calendar year. Findings were discussed with staff from the centers and their comments were incorporated into Marsh's final report, which will serve as a guide for issues that should be examined.

Dr. Stobo reported that several discussions have been held with health and counseling center staff about changes that will be made over a relatively short time. In consultation with Committee Chair De La Peña, Dr. Stobo's office has concluded that its focus during the upcoming several months would be on three major areas: credentialing and privileging, standardization of electronic health records, and appropriate coding of services provided. Initially a July 1 deadline was set for completion of these three areas; however, it had become clear through discussions with staff at the centers that the deadline was unrealistic, particularly with respect to electronic health records and coding. Dr. Stobo stated that substantial progress would be made by July 1, but that the deadline for completion would be moved to later in the year.

Dr. Stobo acknowledged the importance of cost issues to students in the changes to the health centers. He stated that in some areas, particularly the move to the Point and Click electronic health records, the final cost may be less than the current cost, because of savings from economies of scale. Seven campuses currently use the system, which will

be extended to all ten campuses. Regarding work on credentialing, Dr. Stobo reported that the Office of Risk Services in the Office of the President has agreed to fund costs for this effort until July 1. After that point, those costs would be borne by the centers, but re-credentialing is required only every three years. Dr. Stobo stated that his office would do everything possible to adhere to the general guideline of not increasing the cost to students. Dr. Stobo added that his office welcomes and needs student input, and that students are represented on the appropriate work groups. He expressed his hope that costs could be decreased. Dr. Stobo stated that his office is gathering information so that the cost of running the student health and counseling centers can be accurately determined.

Dr. Stobo said that billing practices would be determined by the campus centers; their billing practices would not necessarily be changed. Uniform coding is necessary throughout the system. He acknowledged concerns about confidentiality, but expressed his view that appropriate coding could be done without compromising students' confidentiality. The Office of the President will help facilitate training for the campus centers.

Regent Mireles asked why proper coding of procedures is so important. Dr. Stobo replied that proper coding provides a way to understand the services being provided and whether the services were appropriate to the problem being treated. Proper coding is also necessary for third-party billing. While the student health and counseling centers do not bill third parties currently, it could become necessary in the future under health care reform. Accurate coding is also necessary to understand the work that is being done at the centers for purposes of proper staffing. Committee Chair De La Peña stated that definitions for proper coding are clear in medical practice; coding and diagnosis in a patient's medical records must match, and are very important from a liability perspective. Coding rules are standard throughout the industry and proper coding is a benchmark for best practices. This information is essential in determining whether a facility is being run efficiently. Dr. Stobo stated that proper coding should not affect maintaining patient confidentiality, since both are standard procedures at all medical centers. UCLA Health System President and Chief Executive Officer David Feinberg expressed his view that, if a student's parents were the purchasers of the student's medical insurance, the insurance company would send the parents an Explanation of Benefits (EOB), which would show the date of service, the billing code, and the financial information relating to the visit.

Regent Mireles thanked Committee Chair De La Peña for adding three additional students to the student health steering committee and for scheduling an informational meeting with students during the March meeting.

Faculty Representative Anderson asked about protection of confidentiality for students who are on their parents' health insurance plan and are seen at the student health or counseling centers. Specifically, he asked what information regarding provided health services parents would be given by their insurance providers. Dr. Stobo expressed his understanding that this would be an issue between the provider and the patient, and would not involve the parents. Committee Chair De La Peña stated that, if an insurance company had been billed, their EOB would be mailed to the patient. Dr. Stobo stated that

it would be a violation of Health Insurance Portability and Accountability Act (HIPAA) rules to send the EOB to someone other than the patient. Dr. Feinberg added his understanding that an EOB would be sent to a student's parents if the parents were the purchasers of the insurance. The EOB would show the date of service, the billing code indicating the level of service, and the charges, but would not contain any diagnostic information.

Mr. Anderson asked for a clarification of confidentiality concerns, and asked whether it could be a concern that recording a diagnosis could affect a student's later eligibility for health insurance. Dr. Stobo agreed that could be a concern.

Regent-designate Stein asked under what circumstances a parent would see the code for health care received by a student. He stated that he had received several comments from students concerned about confidentiality in situations where parents could see codes for mental health, sexual health, or substance abuse counseling. Also, he asked whether, if the health centers begin coding for services for which they have not coded in the past, such as outreach for mental health services, an incentive would be created to begin charging for such services or to stop providing them. Dr. Feinberg responded that the EOB would be sent to the purchaser of the insurance; the EOB would show the date of service, the type of service provided such as, for example, "established patient, intermediate visit," and the cost information, such as amounts attributed to a deductible, the co-pay, and the patient's financial responsibility. He stated that parents could determine some things from the EOB that their student might not want them to know, for example, that services were provided by a psychologist or what laboratory tests were done. Dr. Stobo pointed out that any medical services received by a student outside of the student health centers would be similarly coded.

Regarding outreach services, Dr. Stobo stated that there currently exists no code to indicate such services, but that his office is working with personnel from the student health centers to create one. He stated that there should be no incentive to bill for that service simply because it would be coded. Committee Chair De La Peña stated that coding for outreach services would allow the centers to track the time their personnel are spending on such services. Dr. Stobo stated that, if provided services are not coded to reflect their intensity accurately, it is impossible to know what services the center is providing, the true cost of the services, and resources necessary to provide the services.

Regent Pelliccioni suggested that a future Committee meeting include a presentation about privacy provisions under HIPAA and on the use of diagnostic codes for future exclusionary purposes. She noted that there is a federal law that prohibits disclosure of most information, with the unique exception of a student covered by a parent's insurance plan. Dr. Stobo said that his office could provide such a presentation.

Turning to a discussion of the challenges facing UC Health, Dr. Stobo characterized the current time as extraordinary for academic medicine and health care, with the confluence of effects from health care reform, efforts to reduce the federal debt, and employer contributions to the UCRP. Although the outcome of some issues around health care

reform is unresolved, Dr. Stobo stated that forces have been set in motion that would continue in any event. He stated that the only other period he recalled of such financial pressure on health care was around the Balanced Budget Act of 1997, but during that time there had been no federal deficit issues as there are currently. At the current time, there are no additional funds available from outside the health care system.

Dr. Stobo stated that he and his colleagues would provide an overview of the current status of UC Health and the challenges it faces, and some initiatives UC Health is taking to address these challenges. He affirmed that UC Health is in a strong position, both financially and in its reputation. Facing the current challenges will necessarily result in changes in the way UC Health operates, but its personnel have demonstrated extraordinary creativity, innovation, and entrepreneurial spirit.

Dr. Stobo explained that UC Health is an organization of UC's 16 health professional schools, the nursing education program at UC Irvine, the medical education program at UC Riverside, and five medical centers with ten hospitals located on seven campuses. The aggregate budget of UC Health is \$10 billion, almost half of the entire UC budget. By any measure, such as financial success, *U. S. News and World Report* rankings, or the National Institutes of Health (NIH) rankings in terms of research funding, every UC medical center and medical school is exceedingly strong. Dr. Stobo stated that such high quality in a system as large as UC Health is unprecedented in the United States.

Dr. Stobo noted that UC Health gains tremendous benefits from operating as a system, in areas involved with both finance and patient outcomes, including contracting, purchasing, gathering numerical data regarding patient safety and outcomes, and collecting data for clinical trials. Dr. Stobo stated that revenues in the medical center hospitals and medical schools rose from \$9 billion in 2009 to \$10.2 billion in 2011, not including philanthropy. Of this revenue, 76 percent is from the clinical area, 15 percent is from research, and three percent is from the State. The medical centers receive no State funds, but the medical schools receive eight percent of their funding from State funds. Tuition payments represent only two percent of revenue for UC's medical schools. The medical centers have enjoyed good financial margins, slightly more than ten percent in the prior year, and a significant portion of those margins support academic programs in the medical schools. In turn, the medical schools provide the intellectual capacity for UC's medical centers to remain on the cutting edge of their field. Dr. Stobo summarized that UC Health is heavily dependent on clinical and research revenues in order to fund its missions of education, research, and clinical services.

Dr. Stobo turned to challenges facing UC Health. In the area of efforts to reduce the federal debt, the Medicare program, which pays for services UC Health provides to elderly patients and funds \$200 million annually to pay for its residents' training, is a major target for reductions. The National Commission on Fiscal Responsibility and Reform, also known as the Simpson-Bowles Commission, which completed its work earlier in the year, targeted that portion of the Medicare budget for a 60 percent reduction, or \$100 million to UC Health; President Obama's plan would cut that funding by 20 percent. Dr. Stobo expressed his view that the final amount of the cut would be

somewhere between those two figures. Additionally, a significant portion of UC Health's research funding comes from the NIH; that funding is also at risk. Current predictions are that the NIH funding for the upcoming year would be flat or increase less than one percent. Dr. Stobo pointed out that NIH funding would have to increase by three to six percent annually simply to keep pace with inflation in the biomedical sector.

Health care reform has resulted in extreme pressure to decrease cost and increase the quality of health care. Dr. Stobo stated that these pressures will continue regardless of the outcomes of court decisions regarding the Patient Protection and Affordable Care Act (PPACA). Dr. Stobo expressed his view that the California Health Benefit Exchange (CHBE), being developed by the State on a very aggressive timetable, will cause major changes in the health insurance arena.

Regent Pattiz asked how it would be possible to decrease cost and increase the quality of health care. Dr. Stobo expressed his view that UC Health will accomplish these seemingly contradictory goals; there is a great amount of waste and unnecessary utilization in the health care system, increasing cost without adding quality. He noted that the pressure for change comes from internal as well as external sources, as health care providers are initiating efforts themselves to improve outcomes.

Faculty Representative Anderson expressed agreement with Dr. Stobo's assessment of possible reductions in Medicare and NIH funding, and that the federal deficit is of great concern. He expressed his view that the best way to address the deficit would be to allow the tax cuts enacted under former President George W. Bush to expire. He added that a large part of the deficit represents remaining effects of the financial crisis of 2008-09; it would simply take time to restore employment and revenues. Mr. Anderson agreed with Dr. Stobo's assessment that the prospects for incremental federal funding for health care are limited at this point. Committee Chair De La Peña added that insurance companies, affected by the development of the CHBE, will tend to lower reimbursement amounts, resulting in another source of financial pressure on UC Health. Dr. Stobo stated that no one, including patients, employers, and the government, wants to put more money into the health care system at the current time.

UCSF Medical Center Chief Executive Officer Mark Laret stated his view that it is possible to lower cost and increase the quality of health care. For example, the costly duplication of services could be greatly reduced through the use of electronic medical records. UCSF's robotic pharmacy has improved quality and lowered costs. Mr. Laret said it is unknown if such cost savings would be sufficient to solve the financial challenges facing UC Health.

Dr. Stobo discussed UCRP employer contributions, which are a major financial challenge for UC Health and the entire UC system. At the current time, the roughly ten percent employer contribution would remove a large portion of the medical centers' margins. If the employer contribution increases to 17 percent in 2015, the medical centers would have no operating margins, and would operate at a deficit. Even if employer contributions

were capped at 14 percent, the operating margins of the medical centers would be nearly eradicated, with a comparable effect on UC's medical schools.

Dr. Stobo summarized that these areas of significant challenge to UC Health's revenue streams are, in his view, unprecedented. He stated that UC Health is addressing these issues centrally to leverage the advantages of the size of its system. UC Health is also working with other organizations nationally to address these issues in Washington, D.C.

Associate Vice President Santiago Muñoz discussed the current environment for payers to UC Health, stating that more is being spent for health care each year. In California, employers have faced increased health insurance costs of between ten and 13 percent annually for the past three years. In some communities, health care coverage has become unaffordable for working families; enrollment in public programs has grown. The Medicaid program, which provides health care coverage for the state's poor, currently pays for 55 percent of live births in California. The number of uninsured has increased dramatically in recent years, with 20 percent currently uninsured in California. In spite of the high cost of health care in the United States, people are not healthier. Disparities in access to health care are a major problem; UC Health plays an important role in addressing this problem.

Mr. Muñoz stated that these factors led to passage of the PPACA in 2010. He expressed his view that the incentives and disincentives in the PPACA will increasingly shape the behavior of payers to UC Health. There will be significant changes in the way health care will be paid for, and very significant consumer protections, such as requiring provision of online information, ensuring coverage of pre-existing conditions, prohibiting insurance companies from rescinding coverage, eliminating lifetime limits on coverage, regulating annual caps, allowing adult children under age 26 to be covered by their parents' health insurance, and providing small businesses with tax credits. Mr. Muñoz stated that these consumer protections could make health care delivery even more expensive.

Most importantly for UC Health and its contracting partners, the PPACA provides for a significant expansion in health care coverage. This expansion of coverage would finally address what Mr. Muñoz called the hidden tax in California, where those with health insurance pay too much to cover the cost of those who do not pay at all. He stated that the PPACA offers a historic opportunity for UC Health and for the whole country.

Mr. Muñoz explained that, under the PPACA, health insurance coverage is expanded in two ways. First, as of January 1, 2014, Medicaid will be expanded to cover all individuals with incomes at or below 133 percent of the federal poverty level. Second, commercial coverage will be expanded, so that individuals with incomes at or below 400 percent of the federal poverty level who do not qualify for Medicaid will receive a federal subsidy to purchase private insurance coverage. In California, the private insurance coverage will be coordinated through the CHBE administered by the State. The CHBE will create an insurance marketplace with competitively priced premiums. The provisions of the PPACA to expand coverage, the individual mandate requiring individuals to purchase health care insurance, the employer responsibility, and the delivery reforms designed to moderate inflationary pressures will result in expanded coverage for nearly seven million

Californians by January 2014. Mr. Muñoz characterized these changes as a unique opportunity to improve health, to restructure the health care delivery system, and to advance UC Health. He summarized that the provisions of the PPACA will lead to changes in the behavior of UC Health's partners, all commercial health plans, and government health programs.

Regent Pattiz asked if the quality of health care would significantly improve because many people who previously had no coverage would gain coverage. He also asked if the quality of care for those who previously did have coverage would remain as high as it had been. Mr. Muñoz answered in the affirmative to both questions. Committee Chair De La Peña stated that a question remains as to which physicians will provide services to the newly insured seven million Californians, considering the level of Medicaid fees. He stated it is also unknown what level of fees would be paid by private insurers to physicians under the new CHBE for services provided to those individuals who will receive federal subsidies to purchase private health plans. Committee Chair De La Peña cautioned that UC Health might lose a portion of the revenue that it currently receives from Medicaid Disproportionate Share Hospital (DSH) payments. Additionally, UC Health provides services to a large number of undocumented individuals, whose situation is not addressed by the PPACA.

Mr. Muñoz agreed that the incentives and methods of payment to UC Health would change, and that the challenge is to improve outcomes and better reward quality. UC Health must hold itself accountable in the same way its paying partners would hold it accountable.

Regent Zettel expressed her view that issues around the fee-for-service model of payment and the mandate that all individuals, including young healthy ones, buy health insurance would be crucial to controlling costs.

Regent Pelliccioni asked whether the level of payment from Medicaid to UC Health is sufficient to break even for the services provided. Mr. Muñoz responded that payment from Medicaid, even if it were only 80 or 90 percent of cost, would be a significant improvement over receiving no pay at all from the indigent population that currently has no health insurance.

Mr. Muñoz stated that, in California, UC Health is likely the health care system with the most initiatives linked to its own improvement. In the current year, UC Health has \$180 million at risk based on its improvement in measures such as preventing hospital-acquired infections, reducing pressure ulcers, and improving coordination of care. Such improvements are aligned with the goals of the PPACA and the general trend in health care. He stated that the CHBE would encourage risk-sharing payment arrangements between the health plans and the providers, better coordination of care, a reduction in inappropriate use of emergency rooms, more multi-disciplinary provider integration to better manage care, and development of accountable care organizations. Increasingly, payers will not pay for undesirable outcomes. Increasing reliance on narrow networks to provide care could be beneficial to UC Health. Mr. Muñoz commented that UC Health

was instrumental in crafting the Health Net Blue and Gold HMO for UC employees, which narrowed consumer options in health care providers and resulted in substantial savings for UC. He stated that UC Health is making a major investment in the increased use of technology and electronic medical records.

Mr. Muñoz emphasized the importance to UC Health of maintaining excellent relationships with its paying partners. He also noted the value to California of the high-end tertiary and quaternary services offered by UC Health that can be provided only in an academic setting.

Mr. Muñoz displayed a slide illustrating the current sources of UC Health's revenue. In fiscal year 2010-11, six percent of UC Health's patients were uninsured; he anticipates that, as a function of the CHBE and the expansion of Medicaid, the revenue from that six percent will dramatically increase. However, a key factor for UC Health will be the increased pressure on commercial payments.

Faculty Representative Powell stated that the seven million previously uninsured Californians who would gain coverage under the provisions of the PPACA would equal one out of every six people in the state. He asked what portion of that group would start using the services of UC Health. Dr. Stobo responded that, while that would be hard to predict, the number would be significant. He noted that revenue received for the six percent of UC Health's patients who would be newly covered would increase, but that population represents only a small portion of the patient base of UC Health. He stated that, in fiscal year 2010-11, combined Medicare and Medicaid patients represented more than 50 percent of UC Health's patient days, but less than 50 percent of revenue. Most of UC Health's revenue came from its commercial patients, who represented 40 percent of patient days and 61 percent of revenue. Dr. Stobo stated that he anticipates the most pressure on payments from commercial carriers. He said that the increase in UC Health's revenue from 2009 to 2011 was not a result of the relatively small increase in the number of patients served, but rather resulted from better negotiated rates with commercial carriers and the increase in severity of medical conditions treated.

Regent Makarechian asked for clarification of the source of the two percent of revenue that comes from the uninsured. Mr. Muñoz responded that some uninsured patients make cash payments and federal subsidies such as DSH payments help cover the cost of treating the uninsured. Regent Makarechian asked whether the services that UC Health provides vary because of what type of payment will be received. Mr. Muñoz stated that UC Health's standard of care is the highest for every patient, and has nothing to do with a patient's insurance status. All patients are billed uniformly for services rendered, but often pay different amounts for the same services. Regent Makarechian asked how the overall quality of services would improve, if the amounts paid for services would decline over time. Mr. Muñoz pointed out that, as part of the realignment of the delivery of health care services, some Medicaid and Medicare patients currently seen at UC Health might be more appropriately served at other facilities. Over time, UC Health would emphasize its unique tertiary and quaternary services. Dr. Stobo reported that some of UC's medical centers are aligning with lower cost facilities that can be used to provide services not

requiring admission to a high-level care facility. Committee Chair De La Peña commended Mr. Muñoz and his team on their ability to negotiate excellent rates.

Regent Pattiz expressed appreciation for the difficult work of Dr. Stobo and his team. He stated that this trend in health care would continue, and asked what the outcome will be when there is an eventual conflict between improving quality and lowering cost. Dr. Stobo agreed that current changes in the health care field would continue. Committee Chair De La Peña expressed his view that UC, with its 200,000 employees, should consider establishing its own self-insurance plan.

Regent Pelliccioni asked what the effect would be should the PPACA be struck down by the United States Supreme Court. Dr. Stobo expressed his view that pressure to reduce cost and increase quality would continue regardless of the court's decision about the PPACA. Dr. Stobo stated that UC Health is working to achieve these goals proactively, and this work is not dependent on decisions of the courts.

Mr. Anderson stated that the legal challenge to the PPACA has been based primarily on arguments that the Commerce Clause of the United States Constitution should be limited, and expressed his understanding that the State would have the power to pass a similar health care law. He asked General Counsel Robinson if his office had looked into this. Mr. Robinson responded that his office had not investigated this possibility, but that Mr. Anderson's understanding sounded reasonable. Dr. Stobo stated that Massachusetts had passed a health care plan, which Mr. Anderson said implemented an individual mandate that has not been challenged in the court. Dr. Stobo commented that the states could also require their populations to have health insurance.

Chief Executive Officer of the UC Davis Health System, Vice Chancellor for Human Health Sciences, and Dean of the School of Medicine at UC Davis Claire Pomeroy stated that the new climate in health care requires medical centers to decrease cost, and increase value and quality. She commented that the national discussion to date has focused on managing costs within the existing health care delivery system. She expressed her view that costs cannot be controlled without considering fundamental innovations and transformation to a new system of delivering health care.

Dr. Pomeroy reported that such innovation is occurring across UC Health and at UC Davis, for example in new ways of delivering quality care to cancer patients. The new innovations address key challenges of providing increased services to more patients, with decreased funding. UC Davis Medical Center Chief Executive Officer Ann Madden Rice stated that new programs at UC Davis represent a paradigm shift in the ways academic medical centers are serving their communities. UC Davis Medical Center serves 33 counties, many very rural. The traditional model involved cancer patients driving a long way to a large academic medical center for treatment, leaving the familiarity of their own communities. Treatment was fragmented between the medical center and the patient's local physician.

Ms. Rice stated that UC Davis is advancing a new model, enabled in part by improved technology, to deliver care in partnership with local hospitals and local providers, moving care closer to patients' homes. The most complicated cases are still handled at the UC Davis Medical Center in Sacramento, but this center has been augmented with a cancer care network. The two largest partnership arrangements, approved by the Regents, are with limited liability corporations, in addition to two affiliated sites, and two other sites in development. The UC Davis telemedicine program has been used with this network to enable cost-effective consultations and follow-up. UC Davis Medical Center is in the process of securing a five-year \$29 million contract to be the official cancer registry for the State. A meta-registry would be created so that data regarding all care provided on the central campus, throughout the network, and with its partners are available for researchers and would enable more highly coordinated care for patients.

Ms. Rice also reported that UC Davis has a partnership with the Jackson Laboratory to develop innovative personalized mouse models, and another partnership with BGI to conduct large-scale genome sequencing.

Dr. Pomeroy added that these programs would leverage the investment UC Davis made in electronic health records and in its registries to define the clinical manifestations, or phenotype, and link that information to the genotype, or the specific mutation in a patient's cancer. By linking the phenotype and genotype, UC Davis could deliver more personalized chemotherapy of a higher quality, at a lower cost.

Ms. Rice displayed a map showing the location of sites in the cancer care network. UC Davis works with local providers at locally managed sites, which have been very well-received in their communities. The limited liability corporations have been profitable, have repaid their original investments, and have provided some retained earnings to expand services. Telemedicine has allowed creation of a virtual tumor board; local care providers can meet online with pathologists and oncologists from the main Davis campus, and tailor treatment to a patient's individual needs. Such arrangements allow UC Davis to be relevant to more communities in northern California and to provide improved care at a lower-cost site. Partnering communities gain the benefit of health care monies being spent locally.

Dean of the UCSF School of Medicine Sam Hawgood stated that UCSF has enjoyed tremendous success in the past decade. Its research portfolio is now second in the nation, behind only Johns Hopkins Medicine. UCSF's Mission Bay campus contains more than 1.5 million square feet of new research space, with its new 289-bed women's, children's, and cancer hospital under construction, scheduled to open in 2015. The campus continues to recruit top-flight medical students and postdoctoral scholars.

Dr. Hawgood acknowledged that UCSF faces dramatic changes in the health care environment, with expectations of improved performance in all of its missions, at substantially lowered cost. He affirmed UCSF's commitment to build on its research strength to drive innovation with the aim of reducing health care costs, to improve medical education programs to better address societal needs and expectations for the

kinds of physicians UCSF trains, and to improve the quality of care UCSF provides. He acknowledged that necessary change will be painful, since it would involve long-term traditions and cultures. UCSF has many initiatives underway, including internal administrative and supply chain cost-reduction strategies, new affiliations with area hospitals and physician groups, and new insurance models.

UCSF Medical Center Chief Executive Officer Mark Laret stated that the City and County of San Francisco faced a difficult problem in providing affordable health insurance for its employees. It had offered the two options of Kaiser Permanente and Blue Shield of California, but the premium differential between the two continued to grow. Kaiser had lower premiums, since it serves very few Medi-Cal or uninsured patients; Blue Shield's higher premiums cover its insured members and subsidize the public payers. The City asked UCSF to help find a way to lower the cost of the Blue Shield plan, to make it possible for City and County employees to maintain a choice in their health insurance.

In a unique effort, UCSF partnered with Blue Shield and Hill Physicians with the goal of dramatically reducing the cost of care to City and County employees. To date, the feedback from Blue Shield and the City and County of San Francisco has been very positive; financial results will be available in the fall. Dr. Hawgood cited this program as one that could both lower costs and improve care.

Dr. Hawgood stated that there is concern at UCSF that changes on the State and federal level could happen so quickly that there would be little time to develop alternative models of providing care. Given time to adapt, the campus is confident it can develop new models of care. He stated that UCSF would like to build on the successes of the program for Blue Shield and the City and County of San Francisco to develop a program of self-insurance for UC employees, which could both reduce costs and improve the quality of care.

Chief Executive Officer of UC Irvine Medical Center Terry Belmont thanked the Regents for their support of UC Irvine's new medical center, which he said has transformed the Irvine campus, enabled an increase of 30 patients in the average daily census, and changed the image of the medical center in the community. Mr. Belmont reported that UC Irvine Health has many initiatives to address the current challenges to its revenue stream. He noted that UC Irvine Medical Center's five-year financial plan involves having an operating margin of four percent, a volume growth of at least three percent, and net revenue growth of two to three percent. In order to maintain that margin, the medical center must reduce its expenses cumulatively by \$135 million by 2015.

Mr. Belmont said that UC Irvine Health began its Resource Opportunity Improvement the prior year to examine various cost issues, such as the Medicare revenue cycle practices for one-day length of stay, clinical documentation, contracting strategies, and opening a transfer center as a result of the increased capacity of the new medical center. A physician-led Resource Utilization Council focuses on quality and cost. So far efforts have been successful in reducing average length of stay from 6.1 days to 5.9 days, a

5.4 percent reduction in cost per discharge, and in establishing a greater awareness and transparency of data among UCI physicians and staff. Total annual cost savings to date are \$24.6 million.

Dean of the UC Irvine School of Medicine Ralph Clayman stated that his School's goals were to create a culture of alignment and accountability, to use its strategic plan to help with clinical volume, and to develop a funds flow model that was understandable throughout the School. First a strategic plan was created through a year-long process, from which evolved seven themes, each with a strategic planning committee; plans have been implemented since January 2011. A culture change has been implemented by redefining values through the strategic plan; there has been a turnover of 60 percent of the clinical chairs. The current group of clinical chairs is strongly committed to the mission of discovery, teaching, and healing. Mr. Clayman anticipates a revenue increase in the range of \$10 million to \$17 million over the upcoming year; collections have increased by 21 percent.

Dr. Feinberg stated that UCLA Health's goals are to continue to create world leaders in health and science, to discover the basis for disease and for cures, and to optimize health through community partnerships. UCLA Health has increased its focus on patient-centeredness, and has increased its ratings in measures of patient satisfaction from the 38th percentile five years prior to its current 99th percentile ranking. Dr. Feinberg stated that this increase in patient satisfaction has led to a greatly improved business model. In the past, UCLA Health found it necessary to borrow funds from UCLA to meet payroll; currently it has \$600 million in reserves and double digit annual increases in revenue. Dr. Feinberg expressed the view of his organization that this increase in revenues is entirely due to the high level of care received by patients who then recommend UC Health to others. Dr. Feinberg stated that UCLA Medical Center's most pressing problem currently is one of capacity; its new facilities are operating at over 110 percent of capacity, because of the great demand for its services.

To address the challenges of providing improved care at reduced cost, Dr. Feinberg highlighted two interlocking strategies. Regarding primary and secondary care delivered outside of the hospital, UCLA Health is moving care to communities beyond West Los Angeles, into the Central Valley, downtown Los Angeles, and nearby cities, to provide primary care such as pediatrics, obstetrics, internal medicine, family medicine, sports medicine, and dermatology. In the Calabasas area alone, 40,000 patients came to UCLA's outpatient clinics in the past year for primary care, dermatology, and sports medicine. UCLA Health's tertiary and quaternary services have made it world-famous; it provides more organ transplants than any other hospital in the United States. Its kidney transplant program has the nation's highest three-year survival rate.

To deal with increased demand and limited capacity, UCLA Health has determined that, in order to be located at the Ronald Reagan UCLA Medical Center, service will have to be at least at the level of tertiary care and meet the following two goals: be top ten percent in quality and be delivered at Medi-Cal rates. Thus, value is being defined as the best outcome at the lowest cost. Dr. Feinberg stated that this represents a transition from

a volume-based health care delivery system to one of value, where high-quality, low-cost services will be rewarded. Profits will ultimately come from keeping people healthy and out of more costly settings like the hospital.

UC San Diego Health System Interim Chief Executive Officer Tom McAfee expressed his view that, whether the PPACA survives its legal challenge or not, the same charge would still face UC Health, to improve quality of outcomes and decrease cost. He stated that, in the absence of rationing, there are only four ways to cut health care spending: keep people healthy and avoid the need for medical services; try to avoid hospitalizations when patients need medical services; when people do need to be hospitalized, avoid complications, infections, and readmissions; and reduce the cost of care. UC San Diego Health System is focusing on these four areas.

Dr. McAfee stated that current payment systems are not aligned with these goals. For example, a medical provider now makes no money for having patients who avoid the need for medical services or stay out of the hospital. UC San Diego has partnered in a capitated contract with Sterling Health Services Administration to offer a self-insurance product to small businesses in the San Diego area. UCSD will be prepaid for both professional and hospital services, so it will have an aligned incentive to keep subscribers healthy and out of the hospital.

UCSD has programs in place to try to reduce complications once a patient is admitted to the hospital, such as the Delivery System Reform Incentive Payment; the system has 18 programs across four categories with 47 milestones, which are worth \$15 million in the current fiscal year, and \$90 million over five years. There are funds that UC San Diego Health was previously receiving from Medicare that have been put at risk based on the system's performance against these milestones, designed to avoid hospital complications and readmissions. In order to reduce the cost of procedures, UC San Diego Health has also created a department with four pilot projects underway to improve the processes of care delivery.

The opening of the UC San Diego Jacobs Medical Center in 2016 will increase capacity by 30 percent. Should strategies for keeping patients out of the hospital prove successful, hospitals would see fewer patients. Dr. McAfee outlined UC San Diego Health's strategies for growth; these include extending its geographic outreach in the state and internationally.

Dr. Stobo summarized that these presentations were intended to give the Committee a sense of the initiatives underway throughout UC Health to address quickly approaching challenges. He emphasized the importance of using UC's capacity for intellect and innovation to address the serious problems facing health care. Dr. Stobo expressed confidence in UC's leadership ability to successfully advance the health of Californians. Committee Chair De La Peña expressed appreciation for the work of UC Health's leadership.

Regent Newsom recalled his work as San Francisco mayor with Mr. Laret and UCSF on the insurance program for City employees, and the first universal health care plan for a city in the United States. Regent Newsom agreed that it costs much less to keep people healthy than it does to treat them once they have become ill. He anticipated that the upcoming few years would be extremely challenging for health care providers. Pressures on funding of DSH payments will have a significant effect on cities' ability to provide care. Even after the PPACA goes into effect, there would still be millions in California without health insurance. Regent Newsom stated that, even if the tax cuts implemented during the presidency of George W. Bush are allowed to expire, there would still be dramatic cuts in federal funding during the upcoming decade that would have a big impact on UC Health. He noted the importance of the current discussion in addressing ways that UC Health can meet its mission in this difficult economic climate.

The meeting adjourned at 5:05 p.m.

Attest:

Secretary and Chief of Staff