

The Regents of the University of California

**COMMITTEE ON HEALTH SERVICES**

March 17, 1999

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

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

In attendance: Regents Espinoza, Hopkinson, Johnson, Lee, Miura, Montoya, and Moores, Regent-designate Pannor, Faculty Representatives Coleman and Dorr, Secretary Trivette, Associate Secretary Shaw, General Counsel Holst, Assistant Treasurer Young, Senior Vice President Kennedy, Vice Presidents Broome, Darling, Gurtner, and Hopper, Chancellors Bishop, Carnesale, Cicerone, Dynes, and Greenwood, Executive Vice Chancellor Grey representing Chancellor Vanderhoef, and Recording Secretary Bryan

The meeting convened at 1:50 p.m. with Committee Chair Khachigian presiding.

**1. UPDATE ON PARTICIPATION IN CALOPTIMA, MEDICAL CENTER, IRVINE CAMPUS**

It was recalled that the CalOPTIMA program was developed in Orange County in response to the State's initiative to encourage Medi-Cal beneficiaries to enroll in managed care programs. In an effort to redistribute the Medi-Cal patient load and increase access to health care in Orange County, CalOPTIMA sought to increase the number of new hospitals and physicians serving the Medi-Cal population. UCI's primary objective for participation in CalOPTIMA was to continue to provide patient care to the Medi-Cal population, sustain the teaching and research programs of the College of Medicine, and maintain status as a Disproportionate Share Hospital (DSH) provider and a recipient of DSH funding.

At the September 1995 meeting, the Board of Regents authorized the negotiation and execution of a contract with CalOPTIMA for the UCI Medical Center. By doing so, UCI agreed to participate in a capitated system of reimbursement for a majority of the Medi-Cal beneficiaries in Orange County.

The Department of Clinical Services Development has reviewed UCI's role in the CalOPTIMA program in terms of the strategic, financial, and programmatic implications for UCI. Its assessment is that following the implementation of CalOPTIMA, UCI lost a large portion of its Medi-Cal market share. Though Medi-Cal

days have fallen significantly, the UCI Medical Center nevertheless has been able to retain access to Medi-Cal patients and has been successful in retaining the Disproportionate Share Hospital (DSH) payments from the State for providing medical care to its Medi-Cal and indigent population. The increased DSH payments have been an important contributor to UCI's overall financial stability.

Since 1995, UCI has been successful in modifying its reliance on Medi-Cal as a funding source by changing its payor mix and increasing the number of inpatient days attributed to commercial patients. Although CalOPTIMA participation continues to be necessary for carrying out UCI's mission of patient care to the County's indigent, patient days associated with CalOPTIMA are a small component of UCI's overall patient base.

When CalOPTIMA was introduced in the County in October 1995, 38 plans signed a contract. UCI submitted a letter of intent to participate, pending approval by the Board of Regents. Although UCI was concerned about the financial impact of participation, management recognized that it would be difficult to maintain teaching and research programs of the College of Medicine without the Medi-Cal patient base. In addition, it was recognized that the financial viability of the Medical Center would be in jeopardy due to decreases in revenue and in Medi-Cal related DSH funding.

UCI had a number of objectives for its participation in the CalOPTIMA program:

- Continuing to serve the Medi-Cal patient population of Orange County

With the introduction of CalOPTIMA, Medi-Cal beneficiaries were offered a wider choice of providers. Patients who had used UCI for services in the past, when UCI was one of a few providers in Orange County willing to serve this population, now had access to more geographically convenient, community-based providers.

In 1995, UCI estimated it would require 60,000 lives if the Medical Center were to maintain a 30 percent share of the Medi-Cal beneficiaries in Orange County. Though UCI had initially been assigned a large number of Medi-Cal beneficiaries, many of these members have since made a local plan selection. In addition, throughout the state, the number of Medi-Cal beneficiaries has declined as a result of the booming California economy. As of January 1999, UCI has 19,878 enrolled CalOPTIMA members, or around 10 percent of all CalOPTIMA members in the County. However, many of the Medi-Cal patients seen at UCI remain outside of the CalOPTIMA program. UCI's current Medi-Cal inpatient base may be divided into CalOPTIMA enrollees, CalOPTIMA Direct (primarily tertiary referrals from other CalOPTIMA provider plans), and Medi-Cal fee-for-service patients (Medi-Cal eligible patients not covered under the CalOPTIMA program). The bulk of Medi-Cal inpatient days at UCI Medical Center are days associated with patients in Medi-Cal aid categories which remain outside of the CalOPTIMA program.

- Providing adequate protection to UCI's academic programs and preserving the necessary patient base for UCI's residency programs

Traditionally, Medi-Cal patients have provided many of the clinical encounters that supported medical teaching and research programs. With the reduction in total inpatient days, UCI has worked to replace these clinical encounters with other patient populations. The reduction in Medi-Cal days has been partially offset by a significant increase in Contract (PPO and HMO) inpatient days. Overall days have decreased from 99,814 days in 1994, the year prior to the introduction of CalOPTIMA, to 79,445 in the most recent complete fiscal year. This decrease is due both to the loss of Medi-Cal days and a reduction in the length of stay per admission. Though total days have dropped 20 percent, total admissions have declined only 10 percent.

- Protecting a portion of the current UCI Medi-Cal inpatient days to ensure eligibility for the DSH payments

Historically, UCI Medical Center had been the major provider of care to Medi-Cal patients in Orange County, providing 25 percent of all inpatient days of care for such patients in FY 1995. Medi-Cal patients accounted for over 50 percent of UCI's total inpatient days prior to the introduction of CalOPTIMA. Despite the decrease in Medi-Cal inpatient days, UCI Medical Center has had success in retaining the DSH payments for providing medical care to its Medi-Cal population. Due to changes in the hospital-based limits on DSH funding and improved negotiations with the California Medical Assistance Commission, DSH funding has actually increased over the last two years.

- Reducing the financial impact on professional fee revenue

The changes proposed under CalOPTIMA were also anticipated to affect faculty professional fees. In 1995, Medi-Cal payments exceeded \$8 million per year, and in a few departments, constituted over half of all professional fee revenue. Through the change in payor mix achieved by increasing the number of Contract patients, the faculty practice plan has been able to replace much of the lost Medi-Cal revenue.

Based on the population distribution by various aid categories and CalOPTIMA's rate schedule, UCI computed a weighted average capitation rate of \$61.50 per member per month (PMPM) in the original projections. As a result of rate increases as well as the higher acuity patient mix at UCI, the blended rate for UCI across all categories is currently \$101.37 PMPM. During the last fiscal year, UCI received more than \$23 million in capitated revenue from CalOPTIMA patients. Additionally, with net revenue of \$6,000 per discharge, CalOPTIMA-Direct specialty referrals generate approximately \$8 million in net revenue per year.

Hospitalization rates for the majority of UCI's CalOPTIMA patients are comparable to its commercial patient population. However, UCI also gets a substantial percentage of higher acuity patients (aged, blind, and disabled) from CalOPTIMA. Though UCI receives a higher capitation amount for these patients, the costs associated are also significantly higher. The CalOPTIMA population also is a higher user of emergency room services, averaging four times more emergency room visits for its CalOPTIMA patients than for its commercial population.

Though CalOPTIMA enrollment has not reached initially desired levels, management at UCI has taken a number of steps to mitigate the risks associated with participation in the program. Although UCI had been the largest provider of Medi-Cal care in the County, it was not granted a seat on the CalOPTIMA Board of Directors. UCI Medical Center suffered from non-representation on the Board until 1997. A Board seat came available, and UCI Director Laret was appointed to fill it and represent the interests of the traditional safety net providers in the County.

Though the financial losses associated with the loss of Medi-Cal patients has been mitigated by increases in DSH funding, these funds continue to be at risk. A significant change in this funding stream will jeopardize UCI's teaching and patient care missions.

As more counties convert to Managed Medi-Cal models, traditional safety net providers, including academic medical centers, will likely see steep drops in Medi-Cal patient volumes as beneficiaries select from a broader choice of providers. To preserve teaching programs, academic medical centers must be prepared to replace the significant loss of patients or use affiliation relationships to ensure an adequate patient base. UCI has done both.

Director Laret commented that Medi-Cal managed care, as it comes to individual counties, has helped the State achieve its goal of reducing costs and improving access, but it has been very difficult for providers who provide care to low-income patients. Counties have had to protect traditional safety-net providers. UCIMC lost many of its Medi-Cal admissions, but that provided impetus to replace those days with commercially-insured patients. Three years ago, two-thirds of UCIMC's patients were low income, which presented financial difficulties to the hospital. Currently, about half of the patients are low income, and the hospital's census is at a three-year high point.

Committee Chair Khachigian asked whether exit surveys have been made of Medi-Cal patients who have chosen not to return to UCIMC. Mr. Laret responded that surveying has been done. He explained that when CalOPTIMA came into being, Medi-Cal beneficiaries suddenly had many healthcare choices. Many of those providers have since dropped out, generating a return of those patients to UCI. Since the first year, UCI has lost patients at a lesser rate than other health plans.

Vice President Gurtner emphasized how dependent the UC healthcare system is on payments to disproportionate share providers. Regent Leach asked about the

likelihood of their continuation. Mr. Gurtner stated that most of the monies provided by the State in addition to their contract payments for Medi-Cal are predicated on the State's being able to match federal dollars. There is a risk that there is not enough money in the program to continue payments at their past levels. Regent Leach noted that all disproportionate share allocations are being decided not by the marketplace but by political bodies. Mr. Gurtner believed that attempts to save money in the Medi-Cal program ultimately will harm educational programs.

Regent Davies noted that UCIMC had to participate in CalOPTIMA or discontinue as a Medi-Cal provider. He asked whether the drop in inpatient days was expected. Mr. Laret reported that the administration hoped that the hospital would do better. Mr. Gurtner viewed the CalOPTIMA program as a success overall for UCIMC, given its lack of options.

2. **UPDATE ON STRATEGIC PLANNING, MEDICAL CENTER, SAN DIEGO CAMPUS**

This item was withdrawn.

3. **UPDATE ON UCSF STANFORD HEALTH CARE**

Mr. Peter Van Etten, chief financial officer for UCSF Stanford Health, provided an update on the current status of the financial state of the merged entity. Mr. Van Etten reported that UCSF Stanford Health Care was facing serious financial issues. The challenges that initially were thought to be long term have turned out to be immediate. The greatest problem is increasing patient activity in a shrinking inpatient market. In 1998, UCSF Stanford reported a gain in operations of \$20 million, and in the first quarter of 1999, it reported a loss of \$11 million. Unless preventive actions are taken, it is expected that it will lose \$50 million this year, and further reductions in revenue that are projected from Medicare and Medi-Cal and other private payors could result in a loss of \$100 million next year.

Mr. Van Etten posed and answered a number of questions concerning the current financial situation. The first and most important question was whether the merger caused this loss. He believed strongly that it did not. Management did not react as quickly as it should have to the fundamental changes taking place in the marketplace. It was those changes, and particularly the fact that revenue from Medicare, Medi-Cal, and private payors declined while costs increased 4 percent, that caused the current problem. He was confident that the merger will be helpful in dealing with these fundamental changes. The second question was whether one site lost more than the other. He reported that the most significant revenue decline took place in the UCSF campus, due in large part to the larger portion of Medicare, capitated, and Medi-Cal patients at that site.

Mr. Van Etten discussed some of the issues that led to the current situation and his plan to address them. They include the strains that were created by the merger, Medicare reductions, Medi-Cal reductions, commercial health insurance reductions, costs related to Y2K, inpatient activity problems, and cost increases.

Mr. Van Etten believed that management underestimated the complexity of putting together the two medical centers. It was a much larger, more laborious, more difficult job than was anticipated, and there were increased costs over and above those projected, particularly in the area of finance and information technology. Because of this complexity, the audit last year was delayed, and because of that delay, the first quarter report was delayed. He reported that the problems in getting timely information have now been overcome. Another problem was that some accountability was lost in the enthusiasm to create a merged organization and bring together faculties that could work well together. An attempt is being made to put that accountability back into the organizational structure without losing the benefits of integration. Also, much of the time was spent dealing with issues rather than understanding the fundamental changes that were taking place. Finally, the administration delayed making some decisions, particularly about cost reductions, that are being made now. He reiterated that reductions in Medicare reimbursement were at the top of the list of problems. A balanced budget agreement of 1997, which is primarily responsible for the federal budget surplus, was achieved mostly because of reductions in payments to hospitals, and these reductions were disproportionately large for academic medical centers. The aspect of UCSF Stanford Healthcare's Medicare that is provided in support of its teaching program was reduced by \$10 million this year. It will be reduced by \$23 million next year, and by the time the reductions are complete in 2002, it will be \$46 million less. On top of that, President Clinton has proposed further reductions, and Congress has put together a budget proposal that is even more severe.

Mr. Van Etten continued that UCSF-Stanford is the fifth largest Medi-Cal provider in the state. It loses \$80 million a year in treating Medi-Cal patients and was denied a rate increase in 1998. It will lose its disproportionate share funding in July of this year because of the decline in Medi-Cal rolls, which at the Packard Children's hospital have sunk to about 20 percent. He noted that 25 percent is the cutoff point for qualifying as a provider. Even combining its Medi-Cal volume with that of UCSF would not achieve the threshold. Furthermore, commercial health insurance reductions have been significant. On one hand, the merger helped, particularly to negotiate significant increases from Blue Cross and Blue Shield, but on the other, that gain has been offset by the fact that more of UCSF Stanford's private patients and employers are choosing low-price commercial health insurance. As a result, although there has been an increase in Blue Cross and Blue Shield patients, they are capturing a larger market share and bringing in less money. On top of that, there has been a 2 percent increase in capitation on the private side. For every one percent increase, the medical center loses \$6 million, much of it at the north campus.

Mr. Van Etten addressed the cost issues that are part of the reason for the current financial distress. He noted that Y2K represents an enormous challenge, made more difficult by the fact that UCSF's billing system must be replaced. The UCSF infrastructure required significant investment, and the clinical system at Stanford required fundamental changes. An expenditure of \$125 million will be made over two years to address these problems. Also adding to the financial problems is the fact that whereas in 1998 there was a 6 percent increase in discharges, which exceeded projections for the first two years of the merger, during the first quarter of this year this activity was flat. In contrast, other UC hospitals had an increase of 4.5 percent. Because 1 percent of increase in volume produces \$6 million, flat volume contributed to UCSF Stanford Health Care's financial loss.

General cost increases added to the problems. Mr. Van Etten reported that there is a statewide nursing shortage. California ranks 50<sup>th</sup> among all states in nurses per capita, and the average age of these nurses is 47. Significant settlements and wage increases have been paid in order to retain qualified nurses. Drug and supply costs have skyrocketed. A particular issue at UCSF-Stanford was the fact that employees moving from the UC pension plan were not able to bring with them the overfunded aspects of their pension program, necessitating an incremental expense of \$17 million to cover their pension costs.

Mr. Van Etten addressed the question of why UCSF Stanford's financial results differed from those of the other UC hospitals. He noted again that other hospitals in the system do not face the same Medi-Cal reimbursement reductions and diminished disproportionate share payments and do not have to function in an equally hostile economic environment. Many reductions in commercial health insurance are unique to UCSF Stanford, its Y2K costs are probably more severe, its inpatient activity was flat, and it experienced a \$17 million increase for pension costs.

Mr. Van Etten then discussed UCSF Stanford's financial recovery plan. Last summer, when financial losses were first projected for 1999, the Hunter Group was hired as consultant and was charged initially with dealing with that projection, but when it was recognized that the financial problems were going to emerge earlier than was expected, the Hunter Group was charged with working to alleviate immediate problems.

Mr. Van Etten reported that the immediate interventions that have been put into place include freezing hiring and reducing temporary staffing, overtime, travel, and consulting. An attempt is being made to eliminate some of the capacity bottlenecks in intensive care units and operating rooms. In January and February there were increases in activities of about 4 percent, implying that the problem in the first quarter was momentary and may not be repeated. Ways of increasing prices are being considered. It is hoped that Legislators will lend their support to trying to gain rate increases and to reverse losses in disproportionate share funding. Private contracts are being analyzed with a view toward increasing revenue. There is a goal to reduce by

15 percent the \$250 million per year spent on drugs and the \$40 million spent on medical supplies.

The most significant and difficult process under way is to improve productivity through benchmarking labor expenses. In consultation with the Hunter Group, standards have been developed for each of over 200 separate hospital areas, and benchmarks have been set based upon 52 other academic medical centers. A target has been set for UCSF Stanford to be in the lowest 25<sup>th</sup> percentile, except for inpatient nursing areas, operating rooms, and other direct caregiving, where a goal to be at the 50<sup>th</sup> percentile has been set. Achieving that goal would produce a reduction between 10 and 15 percent in employment; some layoffs will be inevitable. Staffing of FTEs per adjusted occupied bed is high at UCSF Stanford compared to similar hospitals. The administration believes that with changes in work and the scheduling and structure of activities, a reduction may be effected without impairing quality or service. Targets for reductions in administrative costs have been set at 40 percent for direct care, 9 percent for patient units, and 27 percent for support areas. Program profitability will be considered, also. That process will include looking at how core institutions are used and how services are organized at the four institutions that make up the merged entity. The effect of any changes on academic programs will be assessed concurrently. The administration has set a baseline to measure quality and service. Patient service, infection rates, and admission rates will be measured periodically and reported to the Stanford Health Care board and faculty to assure that, if errors are made in terms of the reductions that affect service and outcomes, they can be corrected quickly. Work is under way on a new organizational structure to assure accountability. The goals in this process are to return to a break even point next year and to obtain a 3 percent margin in 2001.

Mr. Van Etten noted that the plans that have been put into place should ensure that UCSF Stanford Health Care will not lose \$100 million in 2000 and will be in a position to break even next year. He noted that the operating numbers do not include income on \$400 million in investments. The stock market will have an effect on the actual bottom line.

Mr. Van Etten discussed what he believed were the significant benefits of the merger and what would have happened if the merger had not taken place. Among the benefits was the fact that payments to the two schools increased by \$5 million last year and early this year. He believed that attaining the goal of reducing infrastructure costs by 40 percent would be inconceivable without the merger. By bringing together four complex billing and information systems and other very expensive systems, these costs can be reduced significantly. He believed that UCSF Stanford Health Care is in a stronger market position than UCSFMC was previously.

Lastly, Mr. Van Etten reported an important addition that he believed will have the most significant long-term benefit of the merger. The David and Lucile Packard Foundation, working with the Packard Foundation, has made commitments to develop a program between the schools with a goal to create the nation's preeminent children's



healthcare program. The total investment, which includes grants from the Packard Foundation, fund raising, and NIH funds, totals several hundred million dollars. There will be as many as 20 additional endowed chairs as part of that program. He expected that this children's program, which will be developed during the year, will be of enormous value to the schools and children of California.

Mr. Van Etten believed that if UCSF Medical Center and Stanford Medical Center had not merged, the same reductions in expenses would have been required. While the original business plan for UCSF Stanford Health Care did not show that either institution would have the losses that are projected currently, that business plan assumed that expenses would be reduced by the rate of inflation, which is about 4 percent a year for healthcare institutions, or about what the corrective measures are projected to produce. Medicare, Medi-Cal, and commercial payors would have had their declines regardless. There would have been significant dislocation caused by Y2K, particularly at UCSF. The growth that took place last year and in January and February this year would have been harder to achieve without the stronger market presence that has been established since the merger. UCSF and Stanford would have remained small players among consolidated payors and providers. There would have been no children's health initiative, with its benefits. There would have been fewer opportunities to reduce costs, particularly administrative costs, and fewer opportunities to strengthen academic programs through collaboration, which has taken place most notably in pediatrics. Lastly, the opportunity to learn from each other, particularly through the benchmarking process, would have been lost.

Regent Leach commented that the situation UCSF Stanford Health Care is facing currently will likely be experienced to some degree by the University's other teaching hospitals. He believed that the most significant problems are that revenues continue to decline and that the major revenue sources are not under the University's control. UCSF Stanford Health Care had a 6 percent increase in patient activity last year, with each percentage point's being worth \$6 million. Without that increase in activity, there would have been a substantial loss. The other hospitals have a 4.5 percent increase in activity this year, which is a major help. Increases in patient activity cannot be expected to happen every year, as UCSF Stanford is finding out. Because increases in activity cannot be expected and reductions in revenues are acute, the Hunter Group is adjusting margins to reflect the current situation. Previously, the objective was to have a 3 percent margin. The question now is how to achieve a 7-to-9 percent margin. He emphasized that the Medi-Cal \$80 million loss is not an \$80 million loss below UCSF Stanford's billing rates, it is \$80 million below its costs. He believed it was fortunate that management was looking ahead and recognized seven months ago that the possibility of a \$100 million loss in 2000 existed, even though at that time the budget envisioned a \$44 million profit this year. Management changed its focus to addressing immediate problems. He believed that management was doing a good job also of addressing the problems related to coordinating four different accounting systems, which made financial information late. This year the information was presented a

month earlier. He stressed that the problems addressed by Mr. Van Etten are symptomatic of what UC faces systemwide.

Regent Montoya questioned why, when the possibility of a \$100 million deficit for 2000 came to light months ago, it seemed to catch everyone by surprise that a real deficit emerged last month. Regent Leach reiterated that the budget for this year anticipated a \$44 million surplus, based on expected revenues. The administration predicted accurately the increased costs of 2.6 percent, which was the same level of cost increase being experienced at UC's other hospitals, but the revenues did not materialize. Because the accounting information was late, the UCSF Stanford Health Care board did not know until January that the revenues were not at the expected level and that there would be a serious problem this year. He reported that he and Regent Khachigian, the Regents' representatives on that board, are monitoring the situation and that the executive committee of UCSF Stanford is monitoring management's corrective plans.

Vice President Gurtner emphasized that the projected \$100 million loss was an internal long-range planning number the UCSF Stanford board was informed of and management was directed to prevent. It was not a projected reality but a projected marketplace against which to plan.

Faculty Representative Dorr noted that having hospitals and clinics that function well is essential to the mission of the faculty. She was pleased that the administration is demonstrating concern for the impact the current changes will have on the academic program and is involving the faculty in its planning efforts, in light of the necessity to make some difficult choices about programs. Mr. Van Etten recalled that, by agreement, UCSF and Stanford established an interschool academic council, with representatives of faculty of both schools, to meet with the management of the organization with the purpose of addressing the influences that the clinical enterprise has upon academic issues. The reductions and changes in services are being closely reviewed with medical staff and faculty in the areas that are affected.

Regent Lee stressed that the main focus of UCSF Stanford should be to increase efficiency and the quality of the services without increasing costs. Mr. Van Etten noted that one reason that \$100 million is being spent to build a state-of-the-art information system is to enhance quality and efficiency. Regent Leach believed there is no need to increase prices. He pointed out that the problem is caused not by billing rates but by the fact that Medicare and Medi-Cal pay unacceptably low billing rates. That is what is driving UCSF Stanford Health Care into the red. He noted that pharmacy costs are up 16 percent this year because Medicare and Medi-Cal do not pay any more for the latest medicines prescribed as part of cutting-edge therapies than they do for the least expensive alternatives. Regent Khachigian added that without reduced costs, increased patient activity does not result in increased revenue. The University's hospitals can be full and still be in trouble financially.

In response to a question by Regent Davies, Vice President Gurtner reported that operating numbers for UCSF Stanford exclude investment income. In the first quarter, an \$11 million loss was reduced to \$1 million by the addition of investment income. He predicted a more conservative return on the market in the future, however. He noted that investment income includes only realized capital gains. The funds are invested half with UC and half with Stanford.

Regent Johnson applauded the children's healthcare initiative mentioned by Mr. Van Etten. She asked whether, following the merger, programs had been merged. Mr. Van Etten believed that, because the campuses are forty miles apart, there will not be significant integration of clinical activities. The two campuses serve different markets. He noted that there has been significant consolidation of the billing and information systems and in the clinical areas such as pediatrics. He stated that there is the potential to consolidate in areas of adult medicine in the future.

Chancellor Bishop offered the Regents his assurance as a member of the UCSF Stanford Health Care board that he was giving his full attention to the problem of correcting the health center's financial problems without harming its academic programs, sacrificing the quality of its patient care, or affecting the welfare of its staff adversely.

4. **ACTIVITY AND FINANCIAL STATUS REPORTS ON HOSPITALS AND CLINICS**

Vice President Gurtner discussed the details of the routine report. He noted that in 1997 the operating revenue for the University's medical centers, excluding UCSFMC, dropped from 16 percent to 12 percent. Expenses responded relatively well to this decline in the revenue stream over the past two years, but as the growth factor in revenues continues to be lost, the budget projections to 2000 indicate that there will be an expense growth of 2 percent and a revenue growth of 1 percent. It is clear that a point of diminishing returns will be reached eventually. Regent Davies asked what will happen when this situation starts affecting the University's general budget. Mr. Gurtner believed that it will be difficult to balance the interests of the University with the needs of the State when considering uses for the General Fund. Regent Miura believed that the general public did not understand the connection between Medicare and teaching hospitals. She asked what was being done to educate people concerning this issue. Mr. Gurtner explained that there is a clear perception and growing agreement at the federal level that the medical education piece of the Medicare program needs to be removed and dealt with separately. The Medicare program includes payments to hospitals specifically for educating doctors. If the education payments were separated and made subject to annual budget discussions at the federal level, it is likely the stability of those dollars would be affected adversely. The University's challenge is to try to address the changes in Medicare as they occur. Until the policy governing who should pay for medical education is resolved at the federal level, the University will continue to lose money in its hospital enterprises.

5. **AMENDMENT OF COMPENSATION PLAN FOR STAFF PHYSICIANS**

The President recommended that the Committee approve a technical amendment to the Compensation Plan for Staff Physicians which would include Staff Dentist titles in the plan (see Attachment). It was further recommended that the Committee approve a modification to the Plan which gives the President authority to approve additional Physician or Dentist titles for inclusion in the Plan, as needed. Because this authority is considered operational in nature, it was recommended that it be assigned to the President or his designee.

It was recalled that in November 1997, The Regents approved the Compensation Plan for Staff Physicians. The Plan has continued to serve as an effective vehicle for addressing critical staffing needs by providing a cost-effective, market-sensitive compensation framework. Because of the occupational alignment between Staff Physicians and Dentists, there is generally a commonality in relevant market conditions and compensation practices. Consequently, the University has historically compensated Staff Physicians and Dentists in a similar manner. Originally, it was intended that the scope of this Plan encompass all Staff Physician and Dentist titles. However, the Dentist titles were inadvertently omitted from the 1997 Regents item.

Several campuses have submitted implementation plans for local use of the approved Plan, including UC San Diego, which recently submitted a proposed implementation plan requesting inclusion of Staff Dentist titles.

On an operational level, the use of Physician and Dentist titles is subject to change over time. The authority to approve the inclusion of additional Physician or Dentist titles currently rests with The Regents. Because these actions are considered operational in nature, it is recommended that they be assigned to the President or his designee. The Regents have granted the President similar authority for the Medical School Clinical Compensation Plan.

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

6. **SALE OF DIALYSIS PROGRAM ASSETS, SCHOOL OF MEDICINE, SAN FRANCISCO CAMPUS**

The President recommended that he, in consultation with the General Counsel and the Vice President for Clinical Services Development, be authorized to approve and execute documents necessary to effectuate a sale 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 the San Francisco campus proposes to sell the assets of the UCSF Renal Center located at San Francisco General Hospital with the objective of maintaining a cost-effective and quality program. The proposed transaction is consistent with national trends in which medical schools are reviewing the financial viability of freestanding dialysis units.

The contribution margin of the UCSF Renal Center to UCSF academic programs has been declining over the past few years. The Health Care Financing Administration (HCFA) has financial responsibility for the majority of dialysis care and is considering changes that may reduce payments for dialysis services, including changing the payment model from fee-for-service to capitation payments for end-stage renal disease. These changes may reduce revenue and thereby decrease the contribution margin to the UCSF academic programs.

National firms that acquire regional networks to compete in the managed care marketplace increasingly dominate the market for dialysis services. These companies, because of their size, are able to achieve economies of scale, particularly in regard to purchased supplies. As a leading dialysis provider, Golden Gate Renal Partners is able to achieve competitive advantages and will be more likely to maintain these advantages under a revised compensation structure.

The UCSF Renal Center currently occupies antiquated space at San Francisco General Hospital. The Center needs to be expanded to increase the number of licensed dialysis stations more effectively to accommodate the current patient volume. Inadequate space limits the ability to expand. To renovate the space to comply with current regulations and codes would be prohibitively expensive.

After thorough review, the UCSF School of Medicine determined that the UCSF Renal Center could no longer compete successfully in the current marketplace. An RFP was issued for sale of the UCSF Renal Center, and five qualified responses were received. Responses were evaluated based on the following criteria: ability to serve the current patient base; financial benefit; quality and delivery of care; commitment to research; governance; compatibility with mission; and references. An evaluation committee comprised of two physicians, two UCSF Renal Center staff, and two administrators in the School of Medicine independently reviewed the proposals and narrowed the potential candidates to three finalists. After follow-up presentations, Golden Gate Renal Partners was selected as the firm which best met the established criteria. Golden Gate Renal Partners has been developed as a joint venture between Satellite Dialysis Centers Incorporated and Total Renal Care Incorporated. This joint venture will enable the acquiring company to meet current demands for economies of scale and administrative efficiencies that are being dictated by the changes in the marketplace and reimbursement structures.

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 facility provider number. The transaction will also 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 \$6 million.

Other provisions of the transaction include the following:

- The UCSF School of Medicine will continue to provide physician services. Inpatient services will be provided at San Francisco General Hospital and outpatient services will be provided at the Golden Gate Renal Partners dialysis unit located near San Francisco General Hospital. The UCSF School of Medicine will continue to bill for physician services independent of Golden Gate Renal Partners. Golden Gate Renal Partners will have a contractual obligation to provide documentation required by the UCSF School of Medicine to bill. Golden Gate Renal Partners will not bill for physician services provided by UCSF School of Medicine faculty.
- Golden Gate Renal Partners is required by federal regulation to be licensed by the State Department of Health Services for the provision of dialysis. In addition, Golden Gate Renal Partners will have a contractual obligation to provide data on quality assurance and improvement on a quarterly basis.

- UCSF will retain all cash and accounts receivable as of the closing date, as well as all liabilities of the UCSF Renal Center prior to the closing date.
- Golden Gate Renal Partners will enter into a 7-year Medical Director Agreement with UCSF on behalf of its faculty for an aggregate fee of \$120,000 annually. The UCSF School of Medicine will designate one of its current faculty as the Medical Director.
- UCSF will enter into a 7-year Non-Competition Agreement with Golden Gate Renal Partners. UCSF will covenant that any faculty member with privileges at the Program will be bound by the covenants of the Non-Competition Agreements while said physician remains a member of the UCSF faculty.
- UCSF and Golden Gate Renal Partners will enter into an annual agreement for the provision of dialysis service to inpatients and indigent outpatients. Inpatient dialysis services will continue to be provided at San Francisco General Hospital while dialysis services to indigent outpatients will be provided at the Golden Gate Renal Partner's dialysis facility. The agreement includes agreed upon rates for the provision of such services.
- Golden Gate Renal Partners agrees for sixty days after the effective date of the agreement that all vacant positions will be offered to UCSF employees only. Qualified UCSF employees who apply for open positions in the required time frame will be offered employment with Golden Gate Renal Partners. Individual employees' salaries will be maintained at the current level, unless an individual salary is above the Golden Gate Renal Partners salary scale. Should employees opt not to accept these offers, they will have preferential re-hire rights in accordance with standard University policy.

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

Regent Khachigian recalled that several members of the public addressed the Board concerning the University's mission to patients. Dr. Talmadge King, Chief of Medicine at San Francisco General Hospital, noted that the speakers had five concerns. The first was that the patients who receive this service are indigent and have difficulty getting to and from the center. Many use the bus and walk. He noted that the walk from the bus stop to the new facility is slightly greater but is not uphill. In addition, patients who qualify will be given door-to-door service paid for by their insurers. Patients for whom English is a second language have access to translators at the facility. The patients will continue to be cared for by UCSF physicians and will be seen at San Francisco General Hospital and have access to its pharmacy and support services. The medical center is interested in maintaining its ability to carry on clinical research in this facility. Golden Gate Renal Partners was developed as a joint venture between Satellite Dialysis Centers

Incorporated and Total Renal Care Incorporated. It was chosen on the basis of its interest in supporting clinical research.

Regent Preuss asked why this unit resides in the medical school and not with UCSF Stanford Health Care. Mr. Gurtner responded that San Francisco General Hospital is owned by the County and operated by contract with the University. Therefore, it was not incorporated into UCSF Stanford Health Care.

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 Committee of the Whole, March 17, 1999.]

The meeting adjourned at 3:25 p.m.

Attest:

Secretary



Attachment

**Staff Physicians Compensation Plan Participants:****Titles Eligible for Staff Physicians  
Compensation Plan**

Below is a list of the University titles eligible for participation in this plan. Additional Physician and Dentists titles may be approved, as appropriate, by the President or his designee.

	Title	Title Name
<b>Staff Physicians</b>		
	0767	Medical Service Director
	0768	Senior Physician Diplomate
	0769	Senior Physician
	0770	Associate Physician Diplomate
	0771	Associate Physician
	0772	Assistant Physician
	0778	Consulting Physician
<b><u>Staff Dentists</u></b>		
	0773	Senior Dentist Diplomate
	0774	Senior Dentist
	0775	Associate Dentist Diplomate
	0776	Associate Dentist
	0777	Assistant Dentist

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