The Regents of the University of California

COMMITTEE ON HEALTH SERVICES
October 12, 2004

A Special Meeting of the Committee on Health Services was held by teleconference on the above date at 1111 Franklin Street, Room 9204, Oakland; Murphy Hall, Room 2107, Los Angeles Campus; 777 California Street, Palo Alto; 2220 Lodgepole Circle, Modesto; 1875 Century Park East, Los Angeles; and 2223 Avenida de la Playa, La Jolla.

Members present: Regents Johnson, Kozberg, Marcus, Novack, Pattiz, Preuss, and Sayles; Advisory member Brunk

In attendance: Associate Secretary Shaw, General Counsel Holst, Senior Vice President Mullinix, Vice President Broome, and Recording Secretary Bryan

The meeting convened at 10:11 a.m. with Committee Chair Marcus presiding.

1. **READING OF NOTICE OF MEETING**

For the record, it was confirmed that notice was given in compliance with the Bylaws and Standing Orders for a Special Meeting of the Committee on Health Services, for this date and time, for the purpose of considering matters on the Committee's agenda.

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

Upon motion duly made and seconded, the minutes of the meeting of November 20, 2003 were approved.

3. **UPDATE ON MEDI-CAL REDESIGN AND FEDERAL WAIVER**

It was recalled that in January, Governor Schwarzenegger's Budget proposed to restructure the Medi-Cal program, California's Medicaid program, by obtaining a Medicaid Demonstration Waiver from the federal government. According to the administration, the waiver would allow the State the flexibility to continue providing health care coverage to over 6.7 million eligible Californians. The goals of the redesign are to maintain health care coverage to eligible Californians while containing costs and increasing efficiency.

The Medi-Cal redesign proposal was to be presented to the Legislature on August 2, 2004 but was postponed and will be presented as part of the January budget. According to the State, the proposal may include components that would:

- Revise and simplify the Medi-Cal eligibility and enrollment process.
- Conform benefits to private plans.

- Require monthly premiums, new or increased co-payments, and new co-insurance for certain enrollees.
- Reform Medi-Cal managed care by:
  - Expanding into additional counties.
  - Reviewing and reforming reimbursement policy to ensure access and appropriate use.
  - Encouraging enrollment of the aged, blind and disabled.
- Stabilize funding of the State's safety net to ensure that hospitals have the resources to care for low-income and uninsured Californians.

While the release of the details of the first four objectives have been postponed, work on hospital funding has continued due to the expiration on December 31, 2004 of the federal waiver. The proposed model for reimbursement is based on certified public expenditures for public hospitals and the University of California. It restructures the $2 billion in federal Medi-Cal funding being received, maintaining the level of funding. It also eliminates intergovernmental transfers (IGTs) that have come under close review by the federal government. The State believes that the waiver renewal request that must be submitted by the end of September will trigger a review of California's IGTs and that the program is likely to come under federal scrutiny in the near future.

The Committee was informed that since 1999, State Medi-Cal costs have increased by $3 billion, or 41 percent. The cost increases are attributed to a rise in enrollees, an aging population, and inflation in health care costs. Over the past five years, there have been 1.7 million new beneficiaries, a 32 percent increase, as a result of program expansions and reforms.

The principal funding sources for Medi-Cal are California General Fund revenues, matching federal funds derived from the Federal Medical Assistance Percentage (FMAP), and intergovernmental transfers. All hospitals contracting with the Medi-Cal program negotiate per diem payments, which come from the General Fund and FMAP. Intergovernmental Transfer Programs require counties and other public entities, including the University, to transfer money to the State, which provides the basis for the federal match. The Acute Inpatient Disproportionate Share Hospital (SB 855) is the official federal DSH program. Eligible providers are allowed to receive up to 175 percent of uncompensated costs associated with caring for indigent patients. While the program is funded completely by public hospitals, both private and public hospitals receive payments under the program. The Emergency Services and Supplemental Payment Fund (SB 1255) is a supplemental payment limited to DSH hospitals contracting under the Selective Provider Contracting Program (SPCP) to provide Medi-Cal services and licensed to provide emergency services on site. The Graduate Medical Education (GME or MedEd) program provides a portion of teaching costs associated with hospitals that serve eligible Medicaid recipients through Medi-Cal's SPCP. This funding stream is limited to university teaching hospitals and disproportionate share children's hospitals.

At 14 percent, Medi-Cal is the third largest component of the General Fund budget. It is estimated that Medi-Cal will cost roughly $13.4 billion in General Funds and $31

billion in total funds in fiscal year 2004-05. The State believes that Medi-Cal's share of the General Fund will continue to increase if program changes are not made.

Senior Vice President Mullinix provided details regarding possible outcomes and impacts on all the UC medical centers. He reported that the State's negotiations with the federal government have proceeded smoothly and that it was likely the State would receive the approvals that are being sought. If those approvals are forthcoming, the State will need to develop more fully its plan for the implementation of the program. In further discussions with the federal government, the State must be assured that its plans correspond with federal regulations. It is anticipated that further State legislative approval of the program will be needed before it goes forward.

Mr. Mullinix stated that following the completion of negotiations, it is likely the University will receive roughly the same amount of money it gets from the State, although in a new format. There could be some redistribution of the funds among the hospitals. It is unknown whether the University will be able to influence that redistribution. In the longer term, there is concern that, as the State moves to a capitated program, there will be downward pressures on the cost and reimbursement levels in the program. It is difficult to anticipate the effect of the process in the long term.

Regent Pattiz asked what will determine the distribution of funds. Mr. Mullinix anticipated that there would be separate University funding in the proposal and that its distribution would be the result to some extent of University priorities, although the State will make the final decisions.

In answer to a question by Regent Novack, Mr. Mullnix indicated that Medi-Cal funds amount to about 18 percent of the University's hospital budgets.

While acknowledging Mr. Mullinix's comment that the University is likely to retain its current level of funding, Regent Marcus believed that all the medical centers needed to plan for the worst-case scenario. Any fund reductions would have a substantial and unacceptable impact on them.

4. **ANNUAL UPDATE ON UC IRVINE MEDICAL CENTER, IRVINE**

It was recalled that UC Irvine Medical Center had provided a recent performance update that included information about the transformation of UCI Medical Center and a chronology of the turnaround during the past decade. Data had been provided about faculty recruitment, research funding, and clinical development priorities. A summary on quality by outside independent rating groups preceded an analysis of a number of issues and statistics about patients and occupancy at UCI Medical Center. A summary of the financial situation concluded with challenges and goals for the future, including the development of a new University hospital at the UCIMC site.

Regent Marcus noted the remarkable change in performance over a relatively short period of time. A slide presentation by Executive Officer Cygan covered the following topics:

- The transformation between 1995 and 2004, related to quality and safety, census growth, patient satisfaction, community image, and the energized faculty and staff, including a chronology of events.

- Improvement in faculty recruitments, research funding growth, and quality of results.

- Patient status including satisfaction levels, discharge volumes, daily census levels, and inpatient bed occupancy.

- Financial performance including income, margins, days of cash, and reserves.

- Upcoming challenges including charity care costs and the new hospital.

Among the challenges cited by Dr. Cygan were capacity constraints. There has been a large increase in the daily census at the Irvine hospital over previous years. The intensive care unit and medical-surgical beds are operating at near capacity. Some administrative offices have been vacated in order to add hospital beds, beds have been added to the Emergency Department, and the Medical Center is working with the County and Cal-Optima to move some less acutely ill patients to community hospitals. The Medical Center's role is that of a tertiary and quaternary care provider of specialty services that are different from those offered at a community hospital. County out-patient visits in the Medical Center's speciality clinics have been reduced by as much as 80 percent in the last two years.

Dr. Cygan discussed how the Medical Center plans to deal with the potential drop in Medi-Cal revenue as a result of the federal and State redesign of the program. It is expected that losses in disproportionate share revenues would peak in 2006 and decrease over time; however, those losses may be offset with a new disproportionate share program that is under negotiation. Orange County has a managed Medi-Cal Health Maintenance Organization that disadvantages the Irvine hospital, which gets less revenue from reimbursements than the other UC hospitals. Supplemental revenue is anticipated from the new program, which may be in place by the end of the year. If the Medi-Cal reform program is milder than anticipated, the Medical Center could end up in a stronger financial position in five years than it would have otherwise. If, for some reason, new revenue is not forthcoming from the Cal-Optima program, access to those patients will need to be restricted.

Dr. Cygan addressed another challenge, the growing pressure of the uninsured population. It is a national crisis, but it is particularly severe in California because of the large undocumented population. Many of the hospitals in the community refer these patients to the Irvine Medical Center. He believed that the University's hospitals should be more vigilant in enforcing the laws against referring patients inappropriately. Unfunded costs over the past year have increased significantly.

Unfunded mandates are a challenge also. Dr. Cygan reported that nurse staffing ratios have been legislated, which, because of a shortage, has enabled nurses to demand salary and benefits enhancements. In order to meet the mandated ratios, the Medical Center expects to hire 60 nurses in the next two months, which will add about $3.5 million to its cost structure. The hospital must reach out to Europe and Asia to find the nurses required to fill these positions. Other unfunded mandates include developing electronic medical records, which are very expensive. Bioterrorism and disaster preparedness are major concerns in Orange County, where the Irvine hospital is the major trauma center. Although the community is looking to the Medical Center to be the leader in preparing the community to respond to disasters, the federal and State governments have failed to supply financial support while at the same time expecting hospitals to upgrade systems, equipment, and the types of drugs kept on hand.

Dr. Cygan commented that the last challenge is one that is welcome, the building of the new hospital. A re-bid has been received that is under the maximum allowable contract award. A formal presentation will be made to the Regents in November to discuss the budget and financial plan. Groundbreaking for the facility is expected in the spring, with construction to last approximately four years. He believed the new hospital would ensure the long-term success of health sciences on the Irvine campus.

Senior Vice President Mullinix observed that the Medical Center at Irvine will be the one most directly affected by Medi-Cal reform. Dealing with a capitated program in Orange County is challenging. Even if competitive arrangements can be negotiated, in the longer term there will be continued pressure. Long-term planning includes borrowing about $30 million for construction of the new hospital. He believed that the Medical Center's long-term financial plan, although tight, was viable.

Regent Pattiz asked how breaking ground on and completing the new hospital could help with unfunded mandates. Mr. Mullinix responded that it would provide for a more efficient operation in the longer term, which might facilitate more efficient staffing. A greater emphasis is being put on sharing among the University's medical centers, particularly in the area of information technology, with a view toward saving on developmental expenditures. Dr. Cygan added that the old facility is not conducive to attracting paying patients. The new hospital could attract more of this type of patient and could produce new sources of philanthropy.

Regent Novack asked whether the electronic medical records system was related to the scan codes being developed at the Davis Medical Center to reduce medication errors. Dr. Cygan responded that there are a number of new technologies for matching the doses and timing of medications to specific patients. The UC Irvine Medical Center expects to put some form of the new technology in place as part of its strategic plan.

5. **THE UNIVERSITY OF CALIFORNIA MEDICAL CENTERS ANNUAL REPORT FOR THE TWELVE MONTHS ENDED JUNE 30, 2004, UNAUDITED, OFFICE OF THE PRESIDENT**

Vice President Broome discussed the financial position and results of operations for the twelve months ended June 30, 2004 for each medical center. Using the June 30, 2004 unaudited financial report, which had been distributed to The Regents, key operational indicators, financial results, and trends, as well as comparisons to budget, were presented.

Ms. Broome reported that, although the results were unaudited, no significant changes were expected. She noted that admissions continued to increase, although more slowly than in the prior year. Admissions at the Davis, Irvine, and San Francisco Medical Centers have increased consistently over the last three years. San Diego, which had slightly decreased admissions the previous year, rebounded this year. Los Angeles has continued to decline. It did not receive the expected amount of non-capitated business and was affected adversely by construction at the Santa Monica hospital and the closure of some services.

Ms. Broome noted that patient days were increasing at a faster rate than admissions. The Davis, Irvine, San Diego, and San Francisco Medical Centers have continued to experience an increase over the last three years, driven primarily by admissions. Irvine's increase was driven by admissions as well as an increase in patient acuity, which increased the length of stay and the number of patient days. Los Angeles had a decrease in patient days. She reported that combined outpatient visits rebounded from the previous year. Davis, Irvine, and San Francisco experienced increases. San Diego had an increase, but not sufficient to make up for the previous year's decrease. Los Angeles had decreases both years, based on a decrease in emergency room visits and the closure of the rehabilitative center at the Santa Monica hospital.

Income before other changes in net assets, which represents the bottom line after interest income and interest expense, decreased by about 1.4 percent following a large increase in 2003. Ms. Broome reported that the results are mixed by medical center. UC San Francisco Medical Center's operating results were significantly stronger, with a 7.8 percent operating margin this year versus a 3.7 percent margin last year. San Diego had stronger growth this year after a slight dip the previous year, as it had more Medicare reimbursement patients than anticipated. Los Angeles was affected by weak noncapitated business, but some contracts renegotiated over prior years allowed for some slightly better prices. It managed to eke out a bit more profit this year than last, despite a difficult fourth quarter, when expenses increased 15 percent over the previous year, primarily related to a base of high acuity patients covered by low reimbursement plans.

In a comparison of net patient revenue by funding source, Ms. Broome noted that Medicare, Medi-Cal, and County support were contributing only 43 percent of revenue, versus 47 percent ten years ago. These funds are subject to policy and legislative changes that leave the University vulnerable. It is a concern for all the University's medical centers but affects most seriously those with the highest patient base in these categories. Ten years ago, contracts represented 36 percent of business, compared to 49 percent in 2004. Capitated contract business, which in 2004 was 3 percent, ten years ago was too

insignificant to measure. Commercial business, which represents profitable fee-for-service plans, has dropped during the past ten years from13 percent to 3 percent.

Ms. Broome noted that the growth in total assets for the medical centers was very strong. The largest portion of the almost $500 million increase was due to capital construction, but there were increases also in cash and in receivables because of the increased level of operations that the medical centers are experiencing.

Turning to the category of cash on hand, Ms. Broome reported that three of the five medical centers exceeded 60 days, a benchmark which is considered reasonable based on their backing by the University. UC Irvine Medical Center would have exceeded the benchmark if not for money paid out of its reserves for the new hospital. UCLA Medical Center continues to struggle. Its low cash balance is related to a $75 million loan from the campus. Days of revenue in accounts receivable, another measurement of the current financial position, decreased at every location. Although the Los Angeles and San Francisco medical centers have always been higher in this category because of the nature of their contracts and care, San Francisco has brought its number down, and the new management at Los Angeles will seek opportunities for doing the same there.

Finally, Ms. Broome reported that four of the five medical centers exceeded their budget targets. This was due in large part to the payment of about $30 million related to AB915 and AB918 supplements for outpatient services that had not been included in their budgets. The Los Angeles Medical Center was the exception, although it was close to budget prior to its fourth quarter losses.

In response to a question from Regent Johnson, Vice President Broome reported that The Hunter Group, which had been retained as consultant to UCLA Medical Center to improve its financial condition, recently had finished its contract. Senior Vice President Mullinix recalled that The Hunter Group had set up a series of about 25 actions to be implemented over time in order to improve the Medical Center's balance sheet and operating statements. Progress on those fronts had not been rapid. He believed that it would be beneficial to reexamine some management actions that were taken which appear in hindsight to have been too aggressive and to make some adjustments to the strategic plan that had been laid out. UCLA, which is moving toward an integrated health system, has hired a new CEO of the combined medical enterprise and a new CFO who will be the chief financial officer over both the Medical Center and the School of Medicine. It is hoped that the Medical Center will be able to generate some income growth and improve its cash position through contract negotiations and stronger collection efforts.

Regent Marcus announced that in the spring the Committee would be presented with more detail about the financial condition of UCLA Medical Center and the actions designed to enhance it.

Te meeting adjourned at 11:10 a.m.

Attest:

Associate Secretary