

The Regents of the University of California

COMMITTEE ON HEALTH SERVICES

March 16, 2005

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

Members present: Regents Dynes, Johnson, Kozberg, Lansing, Lee, Marcus, Novack, and Pattiz; Advisory member Brunk

In attendance: Regent Anderson, Regents-designate Rominger and Rosenthal, Secretary Trivette, General Counsel Holst, Senior Vice President Mullinix, Vice Presidents Gurtner and Hershman, Chancellors Bishop, Carnesale, Cicerone, Fox, and Vanderhoef, and Recording Secretary Bryan

The meeting convened at 2:20 p.m. with Committee Chair Marcus presiding.

1. **APPROVAL OF MINUTES OF PREVIOUS MEETING**

Upon motion duly made and seconded, the minutes of the meeting of January 19, 2005 were approved.

2. **UPDATE ON UCSF MEDICAL CENTER, SAN FRANCISCO CAMPUS**

Chief Executive Officer Mark Laret provided a status report on the UCSF Medical Center, including its financial performance, investments made as a result of focusing on the patient care service it delivers, its long-range facility development plans, and the challenges it faces.

Mr. Laret noted that academic success and success in the patient care enterprise are reliant upon each other. Since the dissolution of the UCSF Stanford merger in 2000, UCSF Medical Center has shown strong performance in several areas. The Medical Center developed a strategic plan to solve capacity constraints, grow profitable specialty services, improve financial and operational performance and customer service, and align staff and faculty incentives. He recalled that following the 2000 merger dissolution, the Medical Center was losing \$60 million per year. In FY2001, a loss of \$25 million was budgeted, but only \$16 million was lost. In FY2002, the Medical Center started to achieve profitability, and that success continues. This year the Medical Center expects to exceed last year's \$55 million gain. As important as this gain is, relative to a \$1 billion operating budget it represents only a 5 percent margin.

The Medical Center's positive financial performance has allowed it to build reserves of over \$100 million and to invest more heavily in supporting the academic programs of the medical school. The combination of purchased services, which are medical directorships the hospital purchases for medical school departments, and strategic support, which is money the Medical Center transfers to the medical school to support academic uses, is

approaching \$50 million. Also, the Medical Center has been able to invest heavily in equipment and facilities, consistent with its Strategic Plan. Capital expenditures will top \$100 million in FY2005.

Patient Satisfaction

UCSF has been at the forefront of patient safety, a focus that was reinvigorated in 2000 with the Institute of Medicine's report documenting the lives lost in hospitals due to medical errors. The School of Nursing is working with the Medical Center to develop systems to eliminate common errors.

The Medical Center's financial success is the result of many factors, but the most important is the soaring demand for its services from patients and referring physicians. The number of patients choosing to receive their care at UCSF or referred to UCSF for their care has grown from an average daily census (ADC) of 391 in FY2001 to 444 in FY2004, with demand continuing unabated in FY2005. Much of this growth is the result of successful faculty recruitment. In February 2005, ADC reached 492, about 100 more per day than the average number of patients in 2000. The single largest problem has been the lack of sufficient beds to accommodate this increase.

Patient satisfaction is at an all-time high and was highest among San Francisco hospitals on a recent survey. Successive staff opinion surveys give evidence of significantly improved employee morale. Five years ago, an incentive program based on a percentage of base pay was established to encourage employees to meet quality, patient satisfaction, and financial goals, and a variety of other programs have been instituted to recognize and support employees. Turnover rates are relatively low. UCSF Medical Center is now recognized as sixth among the top ten hospitals in the nation and UCSF Children's Hospital is ranked first in the state.

Facilities and Infrastructure

This progress has been achieved while major investments in facilities and infrastructure have been made. The most important investment has been to add bed capacity to accommodate growing patient volume at both the Mount Zion and Parnassus campuses. Overall capital expenditures, including bed expansion, significant upgrades for radiology and clinical laboratories, expansion of operating rooms, total renovation of the emergency department, and an overhaul of information technology that included computerized physician order entry, have averaged over \$55 million per year in the last four years and should exceed \$75 million in FY2005. The Medical Center expects to invest another \$30 million in information technology in the next few years, as an electronic medical records system is brought on line. It also expects to continue adding beds, at a price of nearly \$70 million in the coming years. Plans are in place to add 100 beds over the next three years, with about 85 at Parnassus and 15 at Mount Zion. Adding these beds will enable programs to be expanded where there is community need, to accommodate transfer patients, expand academic programs, and continue to generate margins that position the Medical Center for its next major investment – new hospital facilities.

UCSF Medical Center's major inpatient facilities – Moffitt and Long Hospitals – are functionally obsolete, and new facilities must be developed to accommodate contemporary medicine and provide additional beds to accommodate projected volume growth. Additionally, under current seismic law Mount Zion Hospital cannot continue as an inpatient hospital beyond 2013. To address these issues, planning has been under way for a new hospital and outpatient or translational clinical site at the Mission Bay campus. The plan, developed in partnership with the School of Medicine and the campus, calls for a women's, children's, and cancer surgery hospital with outpatient or translational research facilities in the first phase at Mission Bay. Parnassus Heights, where Moffitt and Long Hospitals are located, will continue as the Medical Center's full-service, tertiary hospital, with emergency services. Mount Zion Hospital will become a major ambulatory care hub for UCSF. By 2030, there will be inpatient operations at two sites – Parnassus and Mission Bay – as exist at Parnassus and Mount Zion. Details of this project, including program costs and sources of capital, will be reviewed with The Regents as they are developed more fully.

Upcoming Challenges

UCSF Medical Center faces some risks common to all academic medical centers, and some unique to San Francisco. Like others, UCSF shares the challenge of balancing the needs of the academic and business enterprises: managing with uncertainty in the longer-term structure or viability of managed care, Medi-Cal, and the overall healthcare economic environment. UCSF Medical Center is working closely with its sister UC medical centers on improving patient safety and finding additional ways, beyond major group purchasing, to manage the costs of drugs and supplies. UCSF Medical Center shares the challenge of having adequate numbers of nurses and key allied health personnel to staff these complex institutions, and, as capital-intensive organizations, the Medical Center shares a need for access to capital to refurbish and replace obsolete equipment and facilities.

Mr. Laret commented on the most difficult challenge he has faced as CEO. UC academic medical centers are highly complex businesses that try to balance multiple issues – revenue and expense, capital investment, academic development, patient safety, meeting regulatory requirements, community service, and more. He stressed that the reason he was able to present such a positive report on UCSF Medical Center was that the faculty and staff have worked hard for five years to make it happen. He believed that continuing to deliver positive reports depended on the Medical Center's ability to recruit the best talent at every level. UCSF Medical Center operates in the highest cost market in the state. Because of this, to remain competitive it must pay significantly more to staff than elsewhere to recruit and retain talent – in some cases up to 50 percent more than other locations. With the continued success of the clinical enterprise dependent on the quality of people recruited at all levels, UCSF Medical Center's future depends on its ability to compensate individuals at levels that reflect the costs of the San Francisco market.

In conclusion, Mr. Laret observed that UCSF Medical Center in 2005 is a very different place than it was in 2000. Financial performance is strong, patient demand is soaring,

investments are being made in equipment and facilities, there is a long-term hospital replacement plan, and investments are being made in academic programs, and increasing patient satisfaction. The Medical Center is enjoying national recognition as one of the best hospitals in the nation.

Regent Lansing praised the Medical Center administrators and staff for the remarkable turnaround of the past several years.

Noting that beds are being added at Mount Zion Hospital, Regent Johnson asked when downsizing of the hospital would begin in preparation for converting it to an ambulatory care facility. Mr. Laret observed that Mount Zion Hospital lends itself to becoming a major ambulatory surgery center. Its average daily census is about 40, with 61 beds open. Another 15 beds will be added soon to increase capacity. It is planned that by 2013, when a hospital is completed at Mission Bay, the inpatient facilities at Mount Zion can be shut and those beds moved to the new hospital.

3. **UPDATE ON UCSD MEDICAL CENTER, SAN DIEGO CAMPUS**

Vice Chancellor Edward Holmes, Chief Executive Officer of the San Diego Medical Center, provided an update on the Medical Center's progress.

Dr. Holmes recalled that the clinical delivery system supporting UCSD's School of Medicine and Skaggs School of Pharmacy and Pharmaceutical Sciences is based in two distinct regions: Hillcrest, about 13 miles south of the main UCSD campus, and UCSD's East Campus, contiguous with the main campus. Each site supports a hospital, primary and specialty outpatient services, and emergency services.

UCSD Medical Center's performance has been consistently strong in recent years. The average daily census at both hospitals has held steady, as have inpatient admissions and emergency room visits. Outpatient visits have increased each year. UCSD has maintained a balanced payor mix, with a slight increase in Medicare and commercial payors, but with under-compensated and uncompensated care still comprising 44 percent of total inpatient days. The ability to maintain this fragile balance, combined with strategic initiatives to manage expenses and generate revenue, have allowed UCSD Medical Center to sustain a positive operating margin, despite substantial losses due to under-compensated and uncompensated care. The significant challenge of assuring that revenues cover expenses is underscored by the fact that UCSD Medical Center treats about 8.5 percent of the total San Diego inpatient market but provides 36 percent of the uninsured care in San Diego.

Vice Chancellor Holmes commented that maintaining the Medical Center's margin of 6 percent is essential. He noted that 60 percent of the margin is returned to the School of Medicine to support the clinical mission, including the cost of faculty programs for caring for the under-insured and uninsured. Roughly 30 percent of these dollars go directly to offset these costs. Forty percent of the margin is used to support investments

in equipment and facilities. The Hillcrest Hospital, which is 45 years old, is obsolete; about 80 percent of the 40 percent is used simply to maintain the building.

Dr. Holmes reported that the Medical Center's positive performance faces challenges, including declining reimbursements with changes in Medi-Cal and Medicare and predicted adverse changes in the National Institutes of Health budget. Technology, personnel, and pharmaceutical costs are rising, and many facilities are in need of renovation. In the underserved arena, the Medical Center provides \$42 million per year in support after the supplemental State and County funds it receives for under-insured and uninsured care.

UCSD Medical Center-Hillcrest has served as UCSD's main hospital since the University assumed operation of and later purchased it from the County of San Diego in 1966. The Hillcrest Campus is also the site of three outpatient care facilities and office and teaching support space. The hospital has undergone substantial renovation since it was acquired. Even so, the facility is old, obsolete, and inadequate to support the patient care, clinical research, and teaching needs of a major university medical center. Expenditures of \$8 million to \$10 million are necessary for infrastructure upgrades, for example to repair or replace deteriorating electrical, sewage, and mechanical systems. Further, as previously reported to The Regents, the Hillcrest inpatient facility has substantial seismic deficiencies. In light of these issues, UCSD leadership has been evaluating options for replacement of the facility.

The 119-bed Thornton Hospital opened on UCSD's East Campus in 1993. Part of the rationale for building an East Campus hospital was to improve access to UCSD's health system for San Diego's growing north city and county population and the expectation that volume growth from this region would help to maintain the patient-payor mix for the system overall and allow UCSD to continue its substantial service to the underserved. This strategy has been successful; however, as reported to the Regents in May 2004, Thornton Hospital does not have the capacity to meet current and projected demands. At that time The Regents approved preliminary planning for a project that will add a Cardiovascular Center and expand key services at Thornton Hospital. The East Campus is also the site of the Moores UCSD Cancer Center building, the Shiley Eye Center, and the Perlman Ambulatory Care Center.

Dr. Holmes discussed the vision for the Medical Center. Presented with the challenges mentioned, it was decided two years ago to analyze the possible direction of healthcare in San Diego and the nation in the next 20 or 30 years. With the assistance of an independent consulting firm, a long-term vision for the UCSD health care system has emerged that will enable the system to meet the changing needs of patients and the community, support the education and training of physicians and other health professionals, and create synergies enabling the advancement of translational research. The Medical Center's primary goal is to provide the highest possible quality of care and access to it to everyone for whom it is responsible.

Key to this transforming vision is the fact that advances in medicine and technology have fundamentally changed the practice of health care, and a new model is required to respond to new trends. The model that has been established supports the academic and public service missions and will allow continued financial viability. This strategic vision also supports the financial performance necessary for UCSD to sustain its commitment to serve a diverse spectrum of patients and still invest in the programs, facilities, and technologies necessary to provide the highest level of care and service.

Dr. Holmes reported that medical care is moving increasingly to the outpatient arena. UCSD Healthcare, like systems around the country, is used primarily by patients seeking outpatient, urgent, and emergency care services. UCSD Medical Center will generate about 500,000 outpatient visits, 60,000 emergency room visits, and 20,000 inpatient admissions this year. With the increasing sophistication of diagnostic and treatment technologies, this trend will continue. For both outpatient and inpatient care, the UCSD health system has become a regional center, treating patients from throughout San Diego County and beyond. Consistent with national trends, UCSD's hospitals serve increasingly as referral centers for highly specialized services such as burn treatment, high-risk obstetrics, cancer treatment, cardiovascular care, bone marrow and solid organ transplant, and other tertiary and quaternary services. At UCSD, over 90 percent of business is in the outpatient arena, yet 76 percent of expenditures are on inpatient care. Ways must be found of controlling these costs.

In its 2003 report *Academic Health Centers: Leading Change in the 21st Century*, the Institute of Medicine stated that "current training of health professionals emphasizes primarily the biological basis of disease and treatment of symptoms, with insufficient attention to the social, behavioral, and other factors that contribute to healing and are part of creating healthy populations." Recognizing the importance of education and outreach in reducing risk factors and keeping patients healthy, UCSD is committed to developing population-based initiatives that address major public health concerns such as obesity, smoking, and violence – significant and preventable contributors to disease and injury.

Planning therefore has focused on improving and expanding UCSD's outpatient and emergency care centers, which are the services used by the majority of UCSD patients, expanding programming focused on community health and population studies, and creating a modern university hospital that supports the highly specialized programs, multi-disciplinary care, and advanced technologies that are the hallmark of academic medicine.

The long-range vision is a 15- to 20-year plan to create new centers on both the Hillcrest and UCSD East Campuses. Consolidating into a single university hospital over time will be advantageous to maintaining the quality of care and curtailing the duplication of technologies and infrastructure. It has been concluded that hospital beds should be placed near the Medical Center's specialized centers and academic programs in order to promote the teaching and research missions. The Hillcrest Hospital, which is 45 years old, must be replaced. Other facilities, including the Thornton Hospital, the Moores Cancer Center, the Cardiovascular Center, and the Shiley Eye Center, are 10 years old or under and

should not be relocated. Therefore, the best place for consolidation of beds is on the campus, adjacent to the rest of the University.

Dr. Holmes noted that UCSD Medical Center has become a regional provider. Forty-six percent of its patients live in the north city and county, which is San Diego's fastest growing region; 35 percent live in the central and southern portion of the city; 9 percent live in east county; and 8 percent of patients travel from outside San Diego to receive their care; therefore, about 65 percent of the patients live either in the northeast or outside the city. A plan has been developed, to be implemented over 15 to 20 years, that enhances outpatient and emergency care, which are critical for access.

The Hillcrest Campus is proposed to be the home of three centers of excellence:

- An Emergency/Urgent Care Center in new and expanded facilities
- A new center for coordinated community health services
- An expanded outpatient health center

The first investment would be to build a new emergency and urgent care center on the Hillcrest Campus. For many patients, particularly the uninsured, access to health care is through emergency rooms. During the phased implementation of the overall plan, there would be an opportunity to evaluate whether a free-standing emergency room would be practical.

A center for the advancement of community health would focus on preventive medicine. The resources of UC would be brought together with the County health department, possibly San Diego State College, and others in the community.

An early commitment would be to improve the outpatient center, expanding ambulatory care services with outpatient surgery and imaging facilities. A telemedicine program would be developed in conjunction with community clinics.

The East Campus will be the site of:

- Expanded outpatient and emergency services
- Specialty centers focusing on cancer, heart, and eye disease
- A consolidated 500-bed University Hospital, the final phase of the 15- to 20-year transformation

Consolidating services in a 500-bed university hospital would be consistent with the initial vision with which UCSD was planned. The Long Range Development Plan for the campus includes a 650-bed hospital on that site. This would take advantage of the proximity to the Moores Cancer Center, the Cardiovascular Center, the Shiley Eye Center, and Thornton Hospital. With the expansion of outpatient and emergency services, this initiative would improve the academic mission.

Dr. Holmes discussed how the overall plan would unfold over the next two decades. Phase 1 would include building a new emergency and urgent care center on the Hillcrest campus and establishing a center for community health there. During Phase 2, inpatient beds would begin to be consolidated on the East Campus, possibly by moving 175 beds from the Hillcrest campus to the East Campus. Phase 3 would continue to expand and enhance outpatient facilities. At the end of this period, all of the beds would be consolidated on the East Campus. This strategy maximizes the expenditure of resources to create a system that best serves the needs of patients and the region and strengthens the academic and research missions.

Regent Lee noted that UCSD Medical Center takes care of only 8.3 percent of patients in the area but 36 percent of uninsured patients. Dr. Holmes emphasized that caring for the under-insured and uninsured is an important part of the history of the Medical Center. The strategic plan would allow the University to continue to provide access to these patients.

Regent Lansing noted that the Medical Center's proposal is controversial in the San Diego community. She believed, however, that consolidating the hospitals so that they are near centers will increase interaction among highly skilled scientists, which will enhance patient care. She believed also that moving beds would not affect access adversely. She was confident that beds would be available when needed and that new outpatient and emergency room services would be located appropriately.

Regent Pattiz asked how, in the face of the number of emergency rooms that are closing, UCSD Medical Center intends to expand its emergency and urgent care. Dr. Holmes commented that academic health centers are in a precarious position. The concept of a free-standing emergency room is novel in California. About 15 percent of UCSD's emergency patients need to be admitted to the hospital. UCSD would build a facility that would accommodate at least 40,000 emergency room visits and be open all hours. Patients would be stabilized in the emergency room and either kept for observation for 24 hours or less, where they could be attended to using telemedicine, or transported for admission to the main hospital. The campus anticipates that the payor mix for this model would reflect the current payor mix at the Medical Center.

Regent Kozberg asked how the San Diego community is responding to the proposed changes. Dr. Holmes responded that there have been a wide range of opinions expressed. The campus intends to focus attention on the parts of the proposal that may cause concern and to begin to address that concern. The issues that have surfaced include the newly conceived emergency room; moving the trauma center from Hillcrest to the new hospital; and transportation between the sites. In answer to a further question, he reported that an amalgamation with San Diego Children's Hospital had been successful.

Regent Lee observed that there is a shortage of doctors and nurses in the state. Many are educated in other states. He asked how California could increase its number of medical graduates. President Dynes believed that a first step in that direction was illustrated by programs such as one at UC Irvine that trains physicians to be more sensitive to the

healthcare needs of the non-English-speaking community. The program has attracted highly qualified students and will likely be expanded to all the University's medical schools.

Chancellor Fox noted that one of the emerging trends in medicine is to establish teams that specialize in particular procedures. She observed that the consolidation of UCSD Medical Center will provide sufficient patient volume to make sure that that kind of continuing education takes place, which will serve to keep health professionals interested and provide them with new career paths.

4. **MEDI-CAL MIX IMPACT ON CURRENT FINANCIAL STATUS OF UC DISPROPORTIONATE SHARE HOSPITALS (DAVIS, IRVINE, SAN DIEGO)**

Vice President Gurtner recalled that the Regents recently have received reports illustrating a decline in financial performance at certain facilities. While no single problem or issue can be blamed for the demise of a hospital's financial condition, the Division of Clinical Services Development and the medical centers have identified a series of issues which cumulatively have resulted in a less profitable performance. This is of particular concern at the three Medicaid Disproportionate Share Hospitals (DSH) – Davis, Irvine, and San Diego – given the recently proposed changes to Medicaid.

Mr. Gurtner reported that hospital representatives from the Davis, Irvine, and San Diego campuses would provide an update on the financial performance of these hospitals and the strategies in place to address Medi-Cal reform and would cover the following items:

- Local market pressures, including recent changes in the hospital payor mixes and the impact of uncompensated and under-compensated care, which affect hospital financial performance.
- Temporary issues, including payment-timing issues, which have recently affected financial performance.
- Facility-specific strategies in place to address local market pressures that affect hospital financial performance and help ensure that the recently proposed changes to Medicaid do not exacerbate these dilemmas.

Medi-Cal Reform

It was recalled that the medical centers at Davis, Irvine and San Diego rely heavily on federal Medicaid supplemental payments provided through the State's Disproportionate Share Hospital Program, the Emergency Services and Supplemental Payment Program (SB 1255), and the Medical Education Program. These payments are funded through intergovernmental transfers (IGTs) provided by local public entities, including the University of California, which draw a federal match. They are then distributed to the

eligible hospitals. Federal payments total nearly \$2 billion statewide and provide nearly \$150 million to the medical centers at Davis, Irvine, and San Diego. These payments are highly concentrated and represent a growing proportion of the total Medi-Cal payments paid to the recipient hospitals.

The SB 1255 and Medical Education supplemental payments are made through a federal Medicaid waiver that will expire on June 30, 2005. Over the last few years, the federal government has pursued various efforts designed to limit the use of IGTs as the non-federal share of supplemental Medicaid funds. According to the State, the federal government will not renew the current waiver.

In reaction to these developments, the State has pursued a new waiver as the successor payment system. After months of effort, the State has indicated that it has the potential of developing a waiver package with the federal government that significantly reduces the use of IGTs and maintains the hospital supplemental payments. Generally, this structure includes the following:

- Maximizing allowable spending under the federal waiver authority.
- Reconfiguring payments among public and private safety-net hospitals to maximize potential payments under various payment limits.
- Using locally incurred costs at public facilities or certified public expenditures (CPE) for uninsured patients as the non-federal share of Medicaid payments for both Medicaid and uninsured patients.
- Creating a safety-net pool of funding to capture all potential waiver spending opportunities. Payments from the pool would be made to public and private hospitals, including the University. The structure of the safety-net pool allows the State to maximize federal funds under the waiver; however, no discussions have occurred regarding payment distributions. The awarding of distributions from the pool has the potential of becoming politicized. The University's position is that distributions from this pool replace SB 855 DSH, SB 1255, and Medical Education funds.

The success of the new waiver will depend on the successful resolution of many significant implementation issues. The issues include, but are not limited to, effectuating a system predicated on the use of publicly incurred hospital costs or CPEs as the non-federal share of Medicaid payments for both Medicaid and uninsured patients and distributions from the safety net pool. Implementation issues must be overcome in order for the proposal to prove successful.

Vice President Gurtner discussed details of the changes in Medi-Cal for the State of California and nationally. He explained that the revenues obtained by the University's medical centers in the categories Medicare, Medi-Cal, and the uninsured are significant, particularly at the University's disproportionate share hospitals. Under California's

relationship with the federal government, three of the University's five medical centers qualify as DSH, having made a significant commitment to the Medi-Cal community. For inpatient care, the medical centers is paid in two ways. The first is the traditional per diem payment. The State pays the hospital per patient per day, a method that has been in place in California since the implementation of Medi-Cal as a contracted service. The rates vary by hospital. The rest of the revenue comes through supplemental payments that are a combination of programs that have been built over the past 20 years. The three DSH hospitals receive a significant amount of money through these supplemental programs.

The waiver with the federal government is under discussion between the Governor and members of his administration. The University's legislative delegation is active in trying to resolve the issue. The biggest issues are the replacement of the traditional system for paying the supplement (the IGTs), which the government wishes to replace with the CPE system, through which the supplemental funding would be provided directly to the hospitals without going through a State process. The old system provided per diem and supplemental payments which were in great part negotiated against the total expense in the State. The University then was paid an amount not based on expense but on negotiation. The biggest single change is that the State is proposing, in negotiating with the federal government, to deliver a pool that will generate as much as \$450 million in new dollars for California. The University's distribution from the pool will become part of a State negotiation among the University, the public hospitals, the county hospitals, and perhaps other Medi-Cal providers of services at community clinics, and in a sense will be negotiated within the Legislature. More detail will not be known until the agreement with the federal government is completed and the State produces the legislation that will determine the distribution of that pool.

Medi-Cal Managed-Care Expansion

Mr. Gurtner continued that the Governor has also initiated Medi-Cal Redesign, the second part of the package. The Redesign makes major changes in the way health care is provided to Medi-Cal recipients in California. The most significant element in this reform is to move traditional Medi-Cal patients from a fee-for-service program to managed care. The Redesign also creates some new beneficiary cost-sharing situations. Although there is no guarantee that the State Legislature will agree to this, the University is proceeding to analyze the possible effects.

The outcome of the State's discussion with the federal government over the hospital payment provisions is the linchpin to the State's entire Medi-Cal Redesign effort. The centerpiece of the Medi-Cal Redesign effort is the expansion of Medi-Cal managed care to the disabled populations. Under the State's current waiver, the SB 1255 and Medical Education supplemental payments are not available for patients served in a managed-care environment, which results in a significant disincentive for the expansion of managed care. The current waiver proposal would maintain the supplemental payments irrespective of the managed-care expansion.

The State also contends that the use of coordinated systems of care for the disabled populations will result in State savings over the longer term. While the managed-care expansion may result in State savings, it is likely that hospital uncompensated care will increase if the Medi-Cal managed payment rates are not structured appropriately or the current distribution of supplemental payments is not maintained.

Vice President Gurtner introduced representatives of the UC San Diego Medical Center and UC Irvine Medical Center to discuss how they had solved significant financial problems that they experienced during a significant shift in their Medi-Cal base this year.

Chief Executive Officer Richard Liekweg reported that the year-to-date financial figures for the UC San Diego Medical Center were good compared to its operating budget. Operating revenue through January was about 3.5 percent above budget and 7.5 percent above budget compared to the same time last year. This is due in part to the Medical Center's inpatient Medicare case mix having increased by 3.5 percent. Admissions were up almost 1.5 percent over budget compared to the same period last year, and outpatient revenue per visit was up, reflecting some improved contracting and the intensity of the cases treated. At the same time that revenue increased, expenses increased, in part due to the higher daily census and longer patient length of stay through the first six months. The unfavorable variance was also driven by the rate of pay for staff. FTEs compared to adjusted occupied bed are on budget; the rate of their pay accounts for the expense variance. Overall, however, the Medical Center is on target to meet its operating budget of \$28.5 million for the year.

Mr. Liekweg discussed some statistics and trends for the first seven months through February. He reported that patient days are increasing relative to the budget, due in part to admissions increases. The Medical Center expects to finish the year at its targeted length of stay even though in the last four months slightly longer stays have been seen due to the severity of the cases. Emergency room visits, surgical cases, and clinic visits through the year remain on budget. Volumes remain strong. For the period through January, a net gain of just over \$11 million was about \$800,000 behind plan for the first seven months. He reiterated that it is expected that the year-end target will be met.

Mr. Liekweg noted some challenges in this and the next fiscal year in anticipation of possible Medi-Cal changes. He reported that the high price of labor is due to a national labor shortage in nursing and many of the allied health professions. In response to that, the Medical Center has initiated efforts to reduce its reliance on agency or temporary personnel by 25 percent for the remainder of this fiscal year. It is determined to reduce its turnover rate of 11.5 percent in nursing staff by half into the next fiscal year by focusing on retaining the current staff. Efforts have also been focused on process redesigns in the operating rooms, pharmacy, radiology, and laboratory in an effort to increase the number of patients and accelerate procedures in those departments using the resources that are already in place. To address supply and pharmaceutical costs that are increasing at a rate that is higher than inflation, a major redesign effort has been instituted in all areas where supplies are used. Capacity constraints are also an issue. The Medical Center is not in a position to add space; in order to increase capacity it must make the best

use of the space available. Added to that effort are partnerships with the broad network of federally funded community clinics in San Diego, which have been provided access into the Medical Center's patient care information system in order to reduce the duplication of tests. This improves the continuity of care, which should reduce costs. Methods are being assessed for increasing volumes in service lines that have a more favorable operating margin, such as oncology, transplantation, and neonatal intensive care. It is also planned to work toward obtaining better reimbursement rates from commercial payors.

Mr. Liekweg noted that another challenge related to pending Medi-Cal reform is to maintain a balanced payor mix, as noted in the update provided by Vice Chancellor Holmes. UCSDMC provides 36 percent of the care to the uninsured in San Diego while providing only 8.5 percent of the total inpatient care in that market. Care of the uninsured and under-insured, which includes Medi-Cal, accounts for 44 percent of its total inpatient mix. The Medical Center is committed to maintaining this balance, but only if the cost and reimbursement it receives remain balanced. Even after supplemental payments, UCSDMC loses about \$28 million per year on care that it provides to the uninsured and under-insured and about \$14 million per year in caring for those with Medi-Cal.

Mr. Liekweg observed that the Medi-Cal Redesign may affect a large percentage of the Medical Center's patients. Its aged, blind, and disabled Medi-Cal patients represent about 60 percent of its Medi-Cal fee-for-service business. It may be that moving that patient population into a managed care model would cause a reduction in reimbursement for the same level of care. The Medical Center is working with other healthcare providers in San Diego to try to improve reimbursement from the County Medical Services Program. That reimbursement in essence has been capped for the last few years, but by forming partnerships with the other healthcare delivery systems in the county, there is optimism that the pool of funds may be increased. There may also be a sudden increase in the number of those who do not have any insurance. The Medical Center continues to sustain its relationship with federally funded clinics in San Diego, which offer the overwhelming majority of the primary care for Medi-Cal patients who do not have the ability to pay. As Medi-Cal is redesigned, the network of clinics will be essential to preserving the continuity of care for these patients.

Dr. Ralph Cygan, Director of the UC Irvine Medical Center, reported that it shared many of the challenges of the University's other medical centers. Growth continues in the volume of uninsured and under-insured patients, and cost inflation is rising faster than revenue growth. Patient volume is straining the facility's limited capacity and is inhibiting its ability to accept referrals of the very sick and the well-insured patients from other hospitals. The intensive care unit has exceeded 95 percent occupancy since the beginning of this fiscal year, straining the Medical Center's ability to continue to grow and serve the broader needs of Orange County. Another concern in Orange County is that hospitals close to UCIMC are increasingly limiting their capacity and participation in indigent care, particularly in the County Medical Services for Indigent and managed Medi-Cal programs.

Director Cygan reported that the Medical Center lost \$3 million in December, the first loss in three or four years; however, it recovered in January and was reasonably strong in February. It still expects to end the year with a bottom line of \$34 million, which represents an 8.1 percent margin that, although strong, is slightly less than projected. This may be because uninsured costs are increasing, as is the cost of care that is not being matched by increasing revenue. Salaries are a particular issue. Trying to fill nursing positions in order to keep up with the staffing ratios legislated in California is very expensive.

Concerning Medi-Cal reform, Dr. Cygan noted that UCIMC is in a unique position in Orange County with respect to underfunded care. It remains the major safety net provider; more than 50 percent of its patient days are Medi-Cal, managed Medi-Cal, County, and unfunded individuals. Over the last five years, the number of underfunded patients has continued to increase, but so has the number of funded patients, which is putting the strain on capacity. Completion of the replacement hospital is four years away. It will be a challenge to manage this patient growth and address the needs of the community. UCIMC has uncompensated costs approaching \$40 million for this year. These costs must be shifted to other payors, and increasingly that is putting the facility in a position of being uncompetitive, because it must keep raising rates on the insured population. The prospect of having disproportionate share dollars drop with Medi-Cal reform is of concern. Orange County is unique in that there is essentially no outpatient system of indigent care, unlike San Diego, where there are about 12 community-supported, federally qualified clinics. The only two in Orange County are owned and operated by UCIMC. The Medical Center is working with the community and County to shift some of the burden of indigent care more equitably around the county as well as to try to help the community build a system of clinics like San Diego's. The Medical Center is also assessing a plan to shift the management of its two clinics to the community while supporting them with specialty referrals and continuing to use them for teaching.

Dr. Cygan reported that, like UCSD, the Irvine Medical Center is experiencing expense inflation. Although the Medical Center has a task force to track bill payments and is examining ways to trim hospital costs working cooperatively with the University's other medical centers on issues such as purchasing, its ability to control this inflation is limited. It is anticipated that healthcare costs will experience about a 7 percent inflation rate next year, to a great extent driven by nursing salaries. The Medical Center is in the midst of negotiations with the California Nurses Association, hoping to contain the inflation rate at 7 percent, which to an operating budget of \$400 million will add about \$28 million in costs. The Medical Center has also been working to develop its tertiary care programs so as to change its image as a safety net facility to one as a university hospital. Although some progress has been made, it is a difficult strategy to execute as beds become full. An affiliated program with Children's Hospital in Orange County that has been under discussion for several years should come to fruition this year.

In summarizing the Medical Center's position, Dr. Cygan commented that as concerns about the effects of changes in Medicare and Medi-Cal continue, it will be necessary to

help Orange County develop a responsible ambulatory care system in which healthcare facilities share the burden more equitably and to deal with capacity constraints so that UCIMC can continue to function as the major teaching hospital for the School of Medicine and develop the specialty programs that the community desperately needs.

Director Robert Chason reported on the status of the UC Davis Medical Center. He stated that following an unprecedented revenue shortfall in the first half of FY2004-05, the Medical Center experienced a remarkable turnaround. In anticipation of problems, measures were taken early and began to pay off by midyear. He noted that the Medical Center has an organizational structure that integrates the School of Medicine and hospital to an exceptional degree. This has enhanced faculty support for administrative actions that were taken in response to the evolving situation. The Medical Center expects to end the year with a \$20 million net gain, consistent with its budget.

Mr. Chason reported that the previous year the Medical Center began steps to address the anticipated capping of Medicare outlier payments, which are payments received by hospitals for particularly ill patients. Many hospitals were taking advantage of the system by raising their prices in an effort to gain more Medicare dollars. To avoid a calculated loss of \$18 million that would result from the cap, the Medical Center trimmed FTE by about 300. It now faces the problem that other hospitals are trying to transfer their outlier patients to UCDCMC because that business is no longer so profitable. Counties are restricting services, and private physicians are refusing to take Medi-Cal patients, instead referring them to UC Davis. This has become a significant problem in the community. The particular problem is that the UC Davis Medical Center serves an area that reaches to the Oregon border and encompasses many rural hospitals that depend on being able to refer to Davis those patients who need a high level of care.

Mr. Chason reported that the Medical Center's capacity limitations restrict its ability to balance its payor mix and increase its profitable business. A number of strategies for enhancement are being focused upon, including reviewing capital projects every two weeks to monitor construction costs; negotiating a contract with OSHPD to reduce plan checks and manage delays; instituting a hiring freeze; eliminated life flight helicopters; and reimplementing the Emergency Department screening protocol and reopening the Emergency Room to ambulance traffic. A fast track for emergent patients was devised, as was a mechanism whereby Primary Care Network patients can call the hospital directly and be admitted. These strategies have been effective at increasing the number of patients. Admissions, patient days, ER visits, and surgeries have increased, as have clinical visits. Primary care visits are increasing. Gross patient revenue has increased quickly since November; it is anticipated that the 2004-05 budget will be met. Faculty and staff have pulled together; proactive strategies paid off, validating earlier decisions; and valuable lessons were learned, allowing attention to be turned to the coming year.

Director Chason noted that UCDCMC is facing the same issues as all academic medical centers across the country, which are watching Medi-Cal managed care volume in anticipation of the Medi-Cal Redesign. There is a concern that if decisions about the redesign are delayed until late in the fiscal year, the Medical Center will find it

particularly difficult to plan for next year, especially if major cuts in programs will need to be made. It is not easy to make quick changes. Many costs are related to labor, and as there are several employee contracts under negotiation, labor issues could prove divisive. Care must be taken not to do anything that would harm those negotiations. He reported that the administration is analyzing all profitable Medi-Cal product lines and developing contingencies to implement if and when they become less profitable. The Medical Center's County contract is being reexamined. Out-of-county transfers are being reduced, albeit carefully so as to retain strong relationships with small rural hospitals. Out-of-county transfers from larger hospitals with known capacity are being refused. He emphasized that the UC Davis Medical Center wishes to sustain its commitment especially to the under-insured and uninsured, despite their cost to the bottom line. He believed that the future of UCDCMC is dependent on a firm commitment by the federal and State governments to help care for all citizens.

Regent Johnson asked whether the medical centers were taking advantage of any outsourcing or group purchasing. Vice President Gurtner responded that the UC hospitals are one of the oldest participants in group purchasing in the country and are founding members of a group purchasing organization. Although they are well ahead of the curve, all five have groups of pharmacy directors and materiel managers working to find more contract opportunities.

Regent Lee noted that, as the chief purpose of the hospitals is to train students, it is important for them to profit sufficiently to help support their educational mission.

Committee Chair Marcus commended the presenters for the roles they serve in running such complex hospitals in an era of tenuous financing sources. He noted that, with Vice President Gurtner's estimate of the effects of the coming changes in Medi-Cal, the medical centers must focus early on contingency plans based on the most probable outcome. Those plans will lead to costs. Vice President Gurtner responded that the medical centers are budgeting very conservatively for the coming year. By the end of this fiscal year, the effects in future years of the changes in Medi-Cal should become more evident.

The meeting adjourned at 4:15 p.m.

Attest:

Secretary