The Regents of the University of California

COMMITTEE ON LONG RANGE PLANNING
COMMITTEE ON HEALTH SERVICES
January 21, 2010

The Committees on Long Range Planning and Health Services met jointly on the above date at UCSF–Mission Bay Community Center, San Francisco.

Members present: Representing the Committee on Long Range Planning: Regents Bernal, Kieffer, Kozberg, Marcus, Nunn Gorman, and Schilling; Ex officio members Gould and Yudof; Advisory members DeFreece and Simmons; Staff Advisor Martinez
Representing the Committee on Health Services: Regents De La Peña, Island, Lansing, Nunn Gorman, Ruiz, Stovitz, and Zettel; Ex officio members Gould and Yudof; Advisory members Cheng and Powell; Staff Advisor Martinez

In attendance: Regents Lozano, Makarechian, and Varner, Regent-designate Hime, Secretary and Chief of Staff Griffiths, Associate Secretary Shaw, General Counsel Robinson, Chief Investment Officer Berggren, Chief Compliance and Audit Officer Vacca, Interim Provost Pitts, Interim Executive Vice President Brostrom, Senior Vice Presidents Dooley and Stobo, Vice Presidents Duckett, Lenz, and Sakaki, Chancellors Block, Blumenthal, Desmond-Hellman, Fox, Kang, Katehi, White, and Yang, and Recording Secretary Harms

The meeting convened at 8:35 a.m. with Committee on Long Range Planning Chair Kozberg presiding.

ANNUAL ACCOUNTABILITY SUB-REPORT FOR HEALTH SCIENCES AND SERVICES

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

Committee on Long Range Planning Chair Kozberg explained that Senior Vice President Stobo would be presenting the first annual accountability sub-report for health sciences and services. The report would be used as a benchmark in a continually improving evaluative process.

Dr. Stobo informed the Regents that UC Health is a collection of health professionals and hospitals that are interacting within each campus and across campuses to address critical issues related to the delivery of health care and the education of health professionals. He noted that the financial success of UC's hospitals and health professional schools are inextricably linked, and that UC Health faces several significant challenges that can serve as opportunities for continued success.

Dr. Stobo said that UC Health is composed of 16 health professional schools and ten hospitals located on seven campuses. The health professional schools include schools of medicine, nursing, pharmacy, and dentistry, veterinary schools, and schools of public health. The ten hospitals are affiliated with five campuses – San Diego, Irvine, Los Angeles, San Francisco, and Sacramento – plus Berkeley's School of Public Health and Riverside's medical education program. Thirteen thousand students are enrolled in the professional schools. The system employs 5,000 physicians, making it the second-largest physician-provider network in the United States. In addition, it has 60,000 full-time employees, representing nearly half of the full-time employees associated with the University as a whole.

Dr. Stobo remarked that UC's health professional schools and hospitals are state and national leaders in the provision of health care, health-related research, and education. He said that all of UC's facilities are ranked highly when compared to their peers, regardless of the ranking agency, be it *U.S. News and World Report*, the National Institutes of Health, or other evaluating entities.

Dr. Stobo observed that UC Health is a significant component of the University, both in terms of the individuals involved and total expenditures. The University's total expenditures for the last fiscal year were just short of $20 billion; 44 percent of that total, or $8.9 billion, was associated with UC Health. In addition, approximately half of the 2009-10 research budget was tied to UC's health professional schools.

Dr. Stobo showed the Regents slides detailing the operating revenues of the hospitals and medical centers. He noted that the hospitals had been increasingly successful over the past several years, expanding its operating revenue from $4 billion in 2005 to more than $5.5 billion in 2009. Dr. Stobo drew attention to the operating revenue for the medical centers, explaining that the variations between campuses correlate to the capacity of each site. The fact that UCLA may generate more revenue than UC Irvine does not mean that it is operating more efficiently, merely that it has more capacity, and therefore can generate more revenue.

Dr. Stobo remarked that when the hospitals' expenses were subtracted from their net income, the resulting net hospital margins climbed from nearly $250 million in 2005 to $400 million in 2009. He explained that there was a dip in the margin in 2007-08 due to increased expenses associated with updated compliance requirements and pharmacy issues. Dr. Stobo stated that the operating revenue for the past year was the highest in the history of UC. He attributed this success to the hospitals operating as a system, working together, and sharing best practices.

To encourage this cooperative environment, a quarter of the pay-for-performance compensation for the hospital CEOs is linked to systemwide goals. The CEOs collectively agree on a set of goals, and each hospital must meet the goal for that compensation to be paid to any of the CEOs. For instance, if three sites meet or exceed the target, and two do not, then the aggregate system has not achieved its target, and that portion of the CEOs' compensation is not disbursed. Dr. Stobo noted that this approach has provided an incentive for the CEOs to work together to determine best practices so that they function smoothly and seamlessly as a system. He said it

has been instrumental in getting the hospitals to work together and has been a major factor in the financial success of the hospitals.

Dr. Stobo showed a slide illustrating the revenue stream available to UC's hospitals and clinics, noting that it can be divided fairly evenly into two major sources: public payers, such as the federal government through Medi-Cal or Medicaid, and commercial insurance, such as Anthem and Health Net. The hospitals and clinics then transfer $400 million to the University's health professional schools. Approximately $200 million of that is given as payment for purchased services, such as physician services, medical education, or information technology. An additional $200 million takes the form of a cash transfer that goes directly to the health professional schools to support their educational, research, and clinical services programs.

Regent Kieffer sought clarification regarding the transfer, and Dr. Stobo explained that $200 million of the $400 million is for purchased services that are figured into expenses in terms of bookkeeping, before the calculation of the department margin; the $200 million comes out of the overall margin of the hospitals. Once that transfer takes place, only $200 million remains for capital expenses, wages, price increases, and UC Retirement Plan (UCRP) contributions. Dr. Stobo cautioned that the UCRP employer contributions that start in April at four percent will ratchet up to ten percent in three or four years, and will erase that margin. The total UCRP contribution responsibility for the ten hospitals – at ten percent – amounts to approximately $300 million. That expense would result in a negative margin of $100 million without any remainder for capital improvements or wage and price increases.

Dr. Stobo said that a margin of $400 million seems large, but that it is precarious in terms of the calls on that margin to support the health professional schools, the continued success of the hospitals, the financial commitment to employees, and capital expenditures. The transfer from the hospitals and clinics to the schools exceeds the general revenue that the health professional schools get from the State – so while the cutbacks from the State are a threat to the health professional schools, any negative financial results from the hospitals pose a significantly larger financial threat. For their part, the schools play an important role in supporting the clinical enterprise and the cutting-edge clinical service that the hospitals provide.

Dr. Stobo remarked that the UC hospitals play a very important role in terms of addressing the health needs of medically underserved and uninsured populations. He showed a slide comparing the regional market share of hospital beds for four of the five UC medical centers compared to their market share of unsponsored care. Unsponsored, or charity, care refers to medical care that has no sponsor in terms of health insurance; the patient does not have a private sponsor, a public sponsor (e.g., Medi-Cal or Medicaid), or commercial insurance. In explaining the slide, Dr. Stobo used the Davis medical center as an example, stating that it has 19 percent of the area's hospital beds, but 59 percent of its charity care. UCSF has 37 percent of the region's hospital beds, but 83 percent of its unsponsored care. The Irvine and San Diego medical centers demonstrated similar disparities. Dr. Stobo emphasized that the University's hospitals are doing more than their fair share to address the health needs of underserved populations, and that the number of such patients increases every year at each location. Regent Lansing asked why UCLA

was not included in the chart, and Dr. Stobo explained that the Los Angeles campus captures its data differently than the other institutions and it is harder to incorporate; however, the situation at UCLA is comparable to the other medical centers.

Dr. Stobo returned to the importance of the UC Health entities acting and performing as a cohesive system. He reiterated that a quarter of the hospital CEOs' at-risk compensation – their pay-for-performance compensation – is linked to systemwide goals, including resource utilization and quality. This forces the CEOs to collectively identify what successful campuses are doing and what is impeding the success of others. Dr. Stobo informed the Regents that the campuses also contract with insurers as a system, and do not sign contracts until all of the campuses are satisfied with the negotiations. The medical centers share information technology, and are currently considering the implementation of electronic medical records, to facilitate patient and medical communication between campuses. UC Health exercises group purchasing for pharmaceuticals and supplies, and is now conducting system-wide clinical research and educational programs. UC Health is also engaged in various statewide initiatives, such as the California Telehealth Network, the Martin Luther King Hospital initiative, and prison health care reform. In addition, said Dr. Stobo, the system is also engaged in negotiations for the upcoming Medi-Cal waiver renewal, which has a value of $650 million for UC Health.

One benchmark used for determining quality of patient care, said Dr. Stobo, is the rate of specific infections common to hospital settings. In 2007, when the University looked at rates of infection in its medical centers, they were above the national benchmark. However, through three years of best practices, UC Health has decreased the incidence of these infections to the point of being better than the national benchmark. Soon the system will have additional quality indicators, such as 30-day mortality rates, that will enable it to look internally at what it is doing, and compare its results between UC campuses and with other institutions.

Committee on Health Services Chair Lansing noted that every hospital should have a chart showing its mortality rate, but that such a chart can be misleading for UC Health. Because the UC medical centers treat a much greater proportion of medically underserved patients, who tend to be sicker and in more tenuous condition than their mainstream counterparts, their rate of mortality will almost certainly be higher as well. Dr. Stobo agreed and noted that the chart could be corrected for severity of illness, which is an important consideration.

Regent Lozano asked if the UC hospitals have chief quality officers, and if not, how the hospitals ensure patient satisfaction outcomes as well quality medical outcomes. Dr. Stobo affirmed that each hospital has an office that looks at quality indicators, many of which are nationally accepted and some of which the hospitals themselves have developed to ensure patient care. He showed the Regents a slide that graphed campus-by-campus responses to ten questions related to patient satisfaction. When compared to the statewide average, the UC hospitals did reasonably well. Dr. Stobo explained that this type of comparative data is starting to be collected by UC Health and will be shared with the medical centers to drive quality improvement.

President Yudof asked if the decline in infections used as a quality benchmark was included in the incentive plan for pay-for-performance employees. Dr. Stobo said that a reduction in those specific infections was part of the systemwide goals for the CEOs last year as well as for all hospital employees at the campuses. He noted that the incidence of infection depends as much on the technician on the floor who is changing the catheter as it does on the surgeon who puts the catheter in. All employees who touch the patient must work to their best ability to achieve system goals.

Dr. Stobo told the Regents that UC Health faces critical issues: maintaining financial vitality in a changing health care environment (including required UCRP contributions and large capital needs); continued focus on quality improvement and patient satisfaction; the ability of the professional schools to address workforce issues with decreasing State support and evolving delivery systems; and the need for more effective intra- and inter-campus communications and cooperation. He noted that UC Health is a remarkable collection of hospitals and health professional schools that do good for California and the nation. He stressed that it is critical that UC Health continue to be successful and to be viewed as a national leader in terms of access, quality, and the delivery of cost-effective heath care.

Regent Makarechian asked how UC Health accounts for the expense of litigation in its net income. Dr. Stobo said that it is considered an expense; there is a tax levied on the hospitals to support centralized services, including General Counsel services. In addition, if a particular campus has legal expenses that go beyond that, then there is a special assessment on that campus for those legal expenses, which is taken out before the margin is calculated. General Counsel Robinson stated that much of the professional liability is self-insured through the risk program and that the hospitals are assessed a premium based on the payments from the risk program. Dr. Stobo said that the hospitals do contribute to the risk program, but that the cost is shared among the hospitals, so one hospital does not bear directly the total settlement costs. Regent Makarechian stated that if a hospital has no litigation, it must still contribute to the overall pool. Mr. Robinson added that the loss history of each campus is factored in when setting the annual premium for each entity in the pool.

Committee Chair Kozberg noted that it might be helpful to have a litigation benchmark as part of the report. Dr. Stobo agreed and noted that it is an area in which UC Health could improve and save significant amounts of money.

Regent Island commented that the report was informative and expressed a desire to have it updated every year so that the Regents could see the data as a continuum. He asked if, by the term “charity care,” Dr. Stobo was referring to unreimbursed patient care. Dr. Stobo confirmed that to be the case. Regent Island asked what drives the market share for charity care. Dr. Stobo responded that it is largely determined by location and by tradition; individuals know they can go to the hospital and that they will not be turned away simply because they do not have health insurance. Once an individual is in an emergency room, federal regulations prevent providers from making emergency care contingent upon insurance. In addition, some hospitals have a local reputation for taking care of many uninsured patients, and more patients gravitate to that facility

accordingly. Conversely, facilities that make it difficult for the uninsured tend to have fewer of those patients. As an example, Dr. Stobo noted that Davis has a reputation for charity care, and each year it has an incremental increase in the number of patients coming to that hospital. Regent Kieffer noted that this care was perhaps an outgrowth of the historical commitment of the hospitals, and Dr. Stobo added that three of the hospitals had been community hospitals before operation by UC.

Regent Kieffer asked why Dr. Stobo used the term "margin" when describing the pool of $400 million, since costs are applied to that pool. Dr. Stobo agreed that the terminology was problematic. He felt that the term "profit" would be inappropriate and that "margin" was closer in terms of accounting standards. He added that the $200 million cash transfer is really a variable contribution, not a fixed expense. For example, last year it was $100 million; the cash transfer was $200 million this year because the hospitals were so successful financially. He offered that the ebb and flow of that cash transfer to the professional schools reflects the relative financial success of UC hospitals. Regent Kieffer expressed concern that the term could be misinterpreted by the public.

Regent Kieffer observed that the volatility of the margin has a great impact on both the hospitals and professional schools, and it would be useful for the Regents to see a longer period of financial records for the medical enterprises. He recalled a period in which UC Health was very problematic for the University. Regent Kieffer stated that if it becomes a problem again, it will pose a tremendous financial crisis for UC. He asked to see a longer time frame, including the years during which the University had serious financial trouble with its hospitals. Dr. Stobo remarked that he has asked for a systemwide report on the margin as far back as 1990. He informed the Regents that in the aggregate, the margin for UC Health has always been positive; however, individually, several medical centers had been in the red at one point or another. UC Health maintained a two percent margin in the early to mid-1990s, and in the late 1990s, it started to increase. Since that time, the margin has been in the range of four to six percent, which, in terms of public hospitals, beats the benchmark.

Dr. Stobo stated that UC Health has become adept at making sure that it is reimbursed at a fair rate when it negotiates with payers, which contributes to the successful increase of the margin. The Medi-Cal waiver is important to UC hospitals, representing $650 million in reimbursements. UC Health also leveraged its power as a system with regard to expenses. Joint purchasing has been critical, saving UC an incremental $10 million each year. Dr. Stobo explained that the purchasing departments from the five medical centers collaborate to determine how they can best maximize supply management.

Regent Kieffer returned to the issue of fluctuations in the margin, and said it is an issue the Regents ought to be reviewing over time because it impacts how the schools are going to be served. He mentioned that the public should be made aware that the well-being of the schools is closely tied to the fiscal strength of the hospitals. Regent Kieffer also observed that this relationship highlights the connections between research, teaching, and public service. He

emphasized that the public service aspect of UC Health is important and needs to be discussed with the UC Commission on the Future.

Regent Lansing recalled a period eight to ten years ago when the hospitals had problems. She observed that the CEOs, chancellors, and Dr. Stobo have created revolutionary change in making the hospitals come together and share information and systems. She said that the University does not spend enough time talking about its commitment to public service.

President Yudof drew attention to an issue that he felt was not adequately acknowledged by the public, the media, or the Legislature. He stressed that the taxpayers of California are not providing a significant share of the resources needed to produce physicians in California. The majority of UC Health's revenue is the result of the hard work and efficiencies of the medical staff, who produce levels of income sufficient to allow a transfer of assets to the medical schools. Without that transfer, he stated, UC would get less than ten cents on the dollar from the State for what it costs to run a medical school. The President stated that UC's fees for its medical schools are comparatively low, because the relatively small amount of money that could be raised through greater fees is negated by the importance of access to the University. The President said that one of the most positive outcomes of the UC hospitals is that they directly contribute to the creation of the next generation of health professionals for California.

Regent De La Peña asked how much money UC Health makes on its clinical trials, and if they are profitable for the medical schools. Dr. Stobo said he would get that information. Regent De La Peña observed that revenue from clinical trials provides a valuable source of income at some schools.

Regent De La Peña sought clarification regarding the margin amount and then asked how, in the case of a malpractice suit, the settlement is allocated. Mr. Robinson explained that the settlement comes out of a central pool; the campus from which the litigation arises will be assessed the next year based in part upon that loss. Regent De La Peña asked if the campus is assessed or the medical facility. Mr. Robinson said he did not know how the settlement is reflected financially, but that an assessment is made against each of the medical centers at the beginning of the year. Regent De La Peña asked Mr. Robinson to report back to the Regents with information on how settlements are attributed.

Referring back to the patient mortality comparison, Regent De La Peña requested that more indicators be included in the patient outcome data so that it would more accurately reflect the difference in incoming patient health at UC medical centers. Dr. Stobo said he would make sure that it was included in the next report.

Faculty Representative Powell expressed his appreciation of the health sciences centers working as a system, noting that he had wished to see that happen for many years. He said that UC does have a high degree of systematic integration in other areas of the University, but that the health sciences have always been highly independent. Dr. Powell remarked that the new, systemwide

approach will add great benefits to the system as a whole, and that he looks forward to discussions with Dr. Stobo about specific workforce needs and how UC can meet them.

Regent Zettel expressed her amazement at the profitability of UC Health during very troubling economic times. She asked for more information on the goal-based incentives for senior managers, particularly personal goals. Dr. Stobo replied that 30 percent of each CEO's salary is based on performance; of that 30 percent, 25 percent is dependent on achieving systemwide goals, 50 percent is dependent on achieving campus goals, and 25 percent on personal goals for each executive.

Regent Zettel inquired as to the amount of reserves for the system; Dr. Stobo said he did not have the figure with him, but would get it to her. Regent Zettel asked how the UCRP contributions will affect the hospitals' fund transfers and profitability. Dr. Stobo explained that calculations have been done for various levels of contribution ranging from four to ten percent. The figure he discussed earlier, $300 million, is based on a steady-state ten percent contribution. At that level, if nothing else is done to affect the margin, the contribution would erase UC Health's $200 million margin. Regent Lansing asked if UC Health is setting aside greater reserves against this possibility, and Dr. Stobo said it was not, but was looking at increasing the efficiency of its operations.

Regent Ruiz observed that Dr. Stobo is a valuable addition to the University. He told the Regents that Senior Vice President Vacca has been working closely with the medical centers in the last few years on compliance issues; health care is very complicated, is highly regulated, and can result in serious consequences when procedures are not followed. Regent Ruiz said that the medical centers have been very responsive to addressing the issues that have been identified, and complimented the CEOs and the chancellors on working to reduce risk in their health care operations.

Chairman Gould reminded the Regents about the current lawsuit with the County of Sacramento, which he characterized as alarming, for the County's failure to pay its bills. He noted that there is, within local government, much anxiety about late payments from the State. He asked Dr. Stobo if the Davis/Sacramento dispute was an isolated case. Dr. Stobo emphasized that he hoped it would be an isolated case, but as the budget challenges are pushed from the State to the counties, UC Health may see more of issues like this. Chairman Gould asked if the department is developing contingency plans for that possibility, and Dr. Stobo indicated that he intends to discuss it at the next CEO retreat.

Regent Lozano asked that next year's update include more on the mission of teaching and how UC compares against other teaching hospitals. Dr. Stobo acknowledged that it would be good information to include in the reports. For now, he said, UC is above the national norm in terms of diversity, grade point averages, and graduation rates.

Regent Kozberg requested that a benchmark be developed that documents how many UC doctors are from California and how many from elsewhere. Dr. Stobo said he would include that information in the next report.

The meeting adjourned at 9:40 a.m.

Attest:

Secretary and Chief of Staff