The Regents of the University of California

COMMITTEE ON COMPENSATION
COMMITTEE ON HEALTH SERVICES
May 21, 2015

The Committees on Compensation and Health Services met on the above date at UCSF–Mission Bay Conference Center, San Francisco.

Members present: Representing the Committee on Compensation: Regents Elliott, Gould, Kieffer, Lozano, Ortiz Oakley, Reiss, and Saifuddin; Ex officio members Napolitano and Varner; Advisory members Davis and Gilly
Representing the Committee on Health Services: Regents Lansing, Makarechian, Pattiz, Ruiz, Sherman, and Zettel; Ex officio members Napolitano and Varner; Advisory members Davis, Gorman, and Hare; Staff Advisors Acker and Coyne

In attendance: Regents De La Peña, Engelhorn, Leong Clancy, and Pérez, Regent-designate Oved, Secretary and Chief of Staff Shaw, General Counsel Robinson, Provost Dorr, Executive Vice President and Chief Financial Officer Brostrom, Executive Vice President Stobo, Vice Presidents Brown, Duckett, and Sakaki, Chancellors Block, Blumenthal, Hawgood, Khosla, Leland, Wilcox, and Yang, and Recording Secretary Johns

The meeting convened at 1:55 p.m. with Committee on Compensation Chair Kieffer presiding.

INNOVATION IN ORGANIZATION AND LEADERSHIP STRUCTURE, DESIGN AND IMPLEMENTATION, SAN FRANCISCO CAMPUS

[Background material was provided to Regents in advance of the meeting, and a copy is on file in the Office of the Secretary and Chief of Staff.]

Committee on Compensation Chair Kieffer stated that this discussion would inform the Board about changes in the healthcare environment in the U.S. which have a significant impact on academic health systems such as UC Health, affecting all the medical centers and raising compensation issues in a new light. It is also important that the public and the news media understand these issues.

Executive Vice President Stobo began the discussion by describing a paradigm by the futurist Ian Morrison, presented in a 1996 book titled "The Second Curve: Managing the Velocity of Change." According to this paradigm, organizations and businesses typically begin working in an environment with which they are comfortable, with traditional customers and markets, often enjoying success, the "first curve." Something then occurs in their environment to challenge the traditional business model. These organizations and businesses must deal with new markets and customers; some do this well and become more successful, in the "second curve." However, most entities are not able to adapt to a changing environment and fail. Dr. Stobo stated his view

that this paradigm is a fitting description of the state of American medicine, which had been in the first curve for the previous 50 years. In his view the Patient Protection and Affordable Care Act (PPACA) was a tangible manifestation of overall changes already occurring, a disruption that has led to a reexamination of the delivery of health care in the U.S., with a growing emphasis on quality, outcomes, and decreasing costs.

These changes have forced the American healthcare delivery system to consider the second curve of the paradigm. In the first curve, business activity is volume-based in a fee-for-service environment. The second curve presents a value-based environment. For healthcare providers, this means they are compensated only if they add value and improve outcomes. Payment is determined by efficiency and quality, and not simply based on doing something. In the first curve, there is no shared financial risk and compensation is guaranteed. In the second curve, there are partnerships with shared risk. Healthcare providers will be at risk for the care they provide in a fixed reimbursement model. In the first curve, health care focuses on inpatient hospitals. In the second curve, it focuses on populations and their health. There is no incentive for investment in information technology in the first curve. In the second curve, information technology is essential for managing the delivery of health care. In the first curve environment, stand-alone academic medical centers could survive and thrive. In the second curve, scale and systems are needed. Part of the task of sharing risk and rewarding quality is to achieve better alignment of facilities, hospitals, and physicians. In delivering care to populations, there is a strong emphasis on primary care.

The goal of the evolving health system in the U.S. is to effectively manage the use of services, costs, and quality for a large population and to do so under a model of fixed reimbursement. Many academic medical centers in the U.S. are adjusting to these changes. Dr. Stobo stated that the changes currently occurring were easy to see. The challenge for health systems is not to guess what needs to be done or foresee the future, but to accomplish what needs to be done in a reasonable amount of time. He outlined the transition from the first curve to the second curve in the UC health system. The five UC medical centers are moving from being stand-alone hospitals to becoming UC health systems, part of a larger delivery system with a larger population of patients, in partnerships with other groups and facilities. There is a movement from a loose federation of UC medical centers to a virtual system of systems. UC Health is seeking to leverage its scale to affect quality, outcomes, and cost.

Committee Chair Kieffer requested clarification of the idea of UC medical centers developing into health systems. Dr. Stobo responded that in the old paradigm, a UC medical center such as UCSF was a hospital working in loose association with a physician group, without aligning incentives between the physician group and the hospital. The outpatient clinics were also not financially closely aligned with the hospital. In contrast, UCSF was currently forming relationships with other physician groups and other facilities to develop a large network of providers for a larger population of patients in Northern California, beyond the San Francisco Bay Area.

Committee Chair Kieffer asked why UCSF needed to work with a larger network. Dr. Stobo responded that this was being done to spread fixed costs, to lower costs by partnering with entities that have lower costs, to address the healthcare needs of large populations, to be able to

garner contracts from commercial insurers, to compete effectively in the marketplace, and to partner with groups and entities who are as good as UC at understanding how to deliver high-quality health care to large populations.

Committee Chair Kieffer asked if there was a parallel to this in the private sector. Dr. Stobo responded that the consolidation observable in many industries, such as insurance, was also occurring in health care. In the next decade, it was projected that there would be 100 health systems nationally rather than the several hundred currently operating.

Chancellor Hawgood continued the discussion by noting that in 2011-12, UCSF was already aware of the disruption referred to earlier by Dr. Stobo: fundamental change in care delivery and payment models, the consolidation of providers into mega-systems, payments more aligned with the value delivered rather than quantity, and the opening of the California Health Exchanges, which would likely create downward pressure on reimbursement in the commercial insurance market. To prepare itself, the campus engaged Manatt Health Solutions in a year-long planning process in 2013. The goal was to transform the UCSF clinical enterprise, a collaborative partnership between the hospital and the medical group, into an innovative, high-quality, cost-competitive regional healthcare system.

Chancellor Hawgood stressed that all five UC medical centers undertake detailed long-term strategic planning. UCSF had developed three consecutive five-year strategic plans for the period from 2003 to 2018. The 2013 planning process had involved about 400 UCSF physicians and staff and resulted in three essential goals for UCSF. The first is to nurture a culture of continuous process improvement aimed at improving efficiencies and reducing costs in order to be more competitive in the Northern California and national market. The second goal is to become a leader in destination programs, to ensure that UCSF remains outstanding in world-class programs like treatment of complex cancers, intracranial neurosurgery, and solid organ and bone marrow transplants, and to demonstrate quantifiable outcomes for these programs. The third goal is less traditional and has compelled UCSF to reexamine its competencies in population health management. Traditionally, academic medical centers occupy the apex of health care, providing complex, innovative care. In the new environment, UCSF would have to possess greater competency at the base of the healthcare structure, in population health. When UCSF is linked to UC Davis, UCLA, UC Irvine, UC San Diego, and UC Riverside, one can begin to think of this as a California statewide system of population health care. The strategies of the individual UC medical centers work together as part of the larger UC Health vision.

When UCSF began to consider this high-value system of population care for the greater Bay Area, it realized that it could not execute this vision as a stand-alone entity. UCSF does not have the workforce needed to provide care in northern Contra Costa County, southern Santa Clara County, and Santa Cruz County. An important implication of the UCSF strategic plan is that a range of partnerships is required. There is a need to develop new paradigms for collaboration between academic medical centers and leading community hospital systems and physician networks to form what is called a “clinically integrated network,” a term with specific legal implications for contracting. This approach allows UCSF to leverage large existing high-quality community primary care networks, and to coordinate select specialty service lines. From the point of view of cost-effectiveness, these large networks can provide the right care to the right

patient with the right overhead structure. This maximizes efficiency and reduces costs. Shared information technology initiatives are critical in this new paradigm. UCSF also has to consider new executive leadership competencies, particularly in the areas of affiliate management and population health. The competencies required to manage tertiary and quaternary care in an academic medical center are not necessarily the same as those required to provide high-quality but low-cost population health care across a large geographic area.

Committee Chair Kieffer asked about the outcome if UCSF were to remain a traditional academic medical center. Chancellor Hawgood responded that this possibility was considered as one alternative. The conclusions of a study and benchmarking indicated that this would be tantamount to falling into a decline. UCSF would be marginalized as a boutique provider in a larger system, a small player in a heavily consolidated market. In Northern California, in UCSF's market, the large consolidated entities are Kaiser Permanente and Sutter Health, both nonprofit but non-academic health systems. UCSF felt that it was important to perform and compete at their level in the marketplace, and, as part of its training mission, to have the patient base necessary to train across the spectrum from primary care to complex quaternary care.

Five years earlier, UCSF was a stand-alone medical center with a $1 billion annual operation, two hospitals, and a faculty practice group in San Francisco. Currently, UCSF is a $3 billion annual operating health system, with a range of affiliations. In the case of Benioff Children's Hospital Oakland, UCSF has fiduciary and governance responsibilities. A joint venture with John Muir Health was recently announced. Other affiliations involve physician foundations, which are 501(c)(3) structures outside UCSF. Chancellor Hawgood anticipated that the number of such UCSF affiliations would grow. One reason that UCSF engaged Manatt Health Solutions was to benefit from Manatt's national perspective on developments in academic health centers and its particular expertise in the implications of the transition from a medical center to a health system for internal governance and management, and the changes that need to be made in leadership and management teams.

Chancellor Hawgood presented a chart with figures highlighting UCSF's growth from 2005 to 2014. There were significant increases in admissions, outpatient visits, total revenue, and fixed assets. Outpatient visits had increased to well over one million annually.

The strategy UCSF developed in 2013 had several implications: significant increase in scale and complexity of operations, some of which would be new to the organization; closer alignment of governance and management between the School of Medicine, the Medical Center, and the medical group; the need to reduce costs and redundancies; transparency in quality and performance of leadership; a restructured operating model and funds flow; and leadership and management talent commensurate with a complex, highly competitive, rapidly growing business.

Until the previous July, the Medical Center Chief Executive Officer (CEO) and the School of Medicine Dean reported separately to the Chancellor. Under those two reporting structures, UCSF had many redundant administrative functions. Since then, the campus has moved to an aligned system, bringing together the leadership of the hospital and the medical group – they are no longer two separate administrative entities. There is now one contracting office, one compliance office, and one revenue cycle and strategy office. UCSF now has a single

information technology office and integrated human resources operations for the entire campus. Chancellor Hawgood anticipated that these actions would increase efficiency and lower the cost of delivering health care. UCSF was in the process of recruiting and hiring for the new competencies it needs in the areas of system functions, population health, and affiliate management.

In conclusion, Chancellor Hawgood presented an organization chart for the projected management structure of the UCSF Health System. The Chancellor would be the Chair of the Health System. The CEO of UCSF Medical Center would become the President of the Health System. The Dean of the Medical School would become the Vice Chancellor and Vice Chair of the Health System. There are four executive UCSF Health System-wide functions, in finance, strategy and business development, physician services, and clinical operations. Four other executive positions focus on facilities and profit and loss: leadership of the children's hospitals, adult services, cancer services, and affiliate management. This new organization chart reflected the transition to an integrated health system, a move from the first to the second business curve discussed earlier.

Regent Pattiz asked about the effect of these structural changes on overall profit margins. Chancellor Hawgood responded that UCSF's profit margins were healthy, remaining at about six percent, but on a larger base since 2005.

Regent Pattiz asked about the effect the growth of the UCSF Health System would have on net profitability. Chancellor Hawgood responded that UCSF's net profitability has been maintained, and grown a little since 2005. The next five years would be uncertain and there would be especial pressure on UCSF's commercial insurance reimbursement rate. Medicare reimburses about 88 cents per dollar on actual UCSF costs. UCSF would like to break even on Medicare, and this would require reducing the expense base by about ten percent. CEO Mark Laret added that one challenge for UCSF is that its expenses, such as labor contracts, medications, and regulatory requirements, are rising faster than reimbursement increases from managed care contracts. This puts pressure on UCSF profits, 100 percent of which are reinvested in UCSF programs and facilities. The planned growth of UCSF would provide a more diversified base, reduce risk, and eliminate redundancies.

Regent Makarechian requested clarification of figures for UCSF revenues. Chancellor Hawgood responded that, including the campus' research budget, this figure would be $4.5 billion. The budget currently being discussed was the clinical care budget, without any government funding.

Regent Makarechian referred to the organization chart for the new administrative structure and asked that the campus provide figures for how much money the University would save through this consolidation of operations. Mr. Laret responded that the campus would provide this information at a future meeting and indicate specifically where UCSF was eliminating redundant positions. The clarity of such an analysis would be made difficult by the new costs UCSF was incurring. Chancellor Hawgood added that UCSF was coordinating its work with the UCPath program to ensure that it maximizes efficiencies and does not duplicate services, either in technology or personnel. Campuses would still need human resources operations on site, even

with full implementation of UCPath. Dr. Stobo noted that the revenue cycle offices at the five medical centers are working together to identify and replicate systemwide best practices.

Regent Ruiz asked when the University would be able to establish a "system of systems" for all five of its medical centers. Chancellor Hawgood responded that parallel processes were occurring at the medical centers. The medical centers are in frequent communication. No one medical center can enter into a joint venture, merger, or an acquisition that would have negative implications for the overall UC Health system. Each medical center must be responsive to its own marketplace and make local, market-specific decisions, but in the larger context of UC Health. Dr. Stobo added that this objective was already being realized in some areas, such as managed care contracts with commercial insurers.

Regent Ruiz asked if UC Health anticipated building any more medical facilities, or if it already had sufficient geographic reach to serve California. Dr. Stobo responded that UC Health would continue to form partnerships and affiliations with other providers in California, without the need to build, own, or operate every facility. UC Health would rationalize the delivery of health care as a system; for example, there would be agreement about the best medical center or centers for certain procedures in terms of outcome and cost. Chancellor Hawgood remarked that UCSF's strategy assumes a non-federated network, without the need to own all components, unlike the Kaiser or Sutter systems. Information technology and clinical integration would bind the system together, rather than corporate ownership.

Regent Ruiz asked about the role of the UC Riverside School of Medicine in UC Health. Chancellor Hawgood responded that currently, the most significant difference between the UCR School of Medicine and the other five schools is that UCR does not own and operate its own hospital; it would have hospital affiliates instead. Dr. Stobo added that the administrator in charge of the UCR clinical programs meets with the CEOs of the other UC medical centers.

Regent Ortiz Oakley commented that if changes were going to be proposed for positions and compensation, it would be important to understand how the University would offset these increases in compensation by increases in efficiencies. He asked how UCSF's proposed organizational changes would affect its payer mix and its revenue model. He asked how the University's knowledge and experience of changes in the medical profession are included in the training of professional school students. In response to the first question, Mr. Laret responded that UCSF takes its responsibility of public service very seriously. The current sponsor mix is between a quarter and a third Medi-Cal, between a quarter and a third Medicare, and the rest commercial insurance. The payer mix for UCSF's competitors is weighted much more toward commercial insurance. UCSF seeks to achieve an appropriate balance, serving communities and exposing students and trainees to the range of medical needs in society, and yet generating revenues that can support UCSF's capital and programmatic needs. Almost one-third of Californians are currently covered by Medi-Cal, and there is much discussion of the chronic underfunding of the Medi-Cal program. UC Health is committed to the care of the underserved in the state. Dr. Stobo added that one motivation for the proposed changes at UCSF is to arrive at a cost structure that allows the campus to serve Medicare and Medi-Cal patients.

In response to Regent Ortiz Oakley's second question, Chancellor Hawgood responded that there are significant implications for health professional education at this time. UCSF has embarked on major curriculum reform, taking a long view and considering the health system environment that its graduates will be working in. The students to be enrolled in the current year at UCSF would begin to practice independently for the first time in 2025.

Regent Engelhorn observed that there have been great changes since the founding of the University's medical schools. The changes currently proposed for UCSF were dramatic. He asked about the Board's qualification to administer this kind of health system, which would raise complex issues, including high salaries for certain positions. President Napolitano responded that the University had already embarked on the work of examining the governance structure for UC Health and had engaged the RAND Corporation to study the issue.

Regent Lansing expressed confidence in the leadership of UC Health and in the fact that UC Health was ahead of the curve of change in its business operating environment. The University was exploring new models for governance in this area. She recalled that UC hospitals had not always been profitable.

Committee Chair Kieffer called attention to the magnitude of a six percent profit in relation to an organization the size of UCSF. He remarked that taking action on compensation had both offensive and defensive aspects. There was a risk in taking no action, but a different kind of risk in acting.

The meeting adjourned at 2:50 p.m.

Attest:

Secretary and Chief of Staff