

The Regents of the University of California

HEALTH SERVICES COMMITTEE

December 5, 2016

The Health Services Committee met on the above date at the Luskin Conference Center, Centennial Hall, Salons C & D, Los Angeles campus.

Members present: Regents Lansing, Reiss, and Sherman; Ex officio member Lozano; Executive Vice President Stobo, Advisory members Dimsdale and Lipstein

In attendance: Secretary and Chief of Staff Shaw, Deputy General Counsel Nosowsky, and Recording Secretary Johns

The meeting convened at 10:05 a.m. with Committee Chair Lansing presiding.

1. PUBLIC COMMENT

Committee Chair Lansing explained that the public comment period permitted members of the public an opportunity to address University-related matters. The following persons addressed the Committee concerning the items noted.

- A. Ms. Monica De Leon, hospital unit service coordinator at the UC Irvine Medical Center, expressed concerns about layoffs that had taken place recently at the Medical Center. She described the laid-off workers as frontline caregivers and the layoffs as unnecessary and dangerous. Ms. De Leon warned that remaining staff were being asked to do more with less, that this affected staff's ability to provide patient care, that patients were being neglected, and that this situation was causing deterioration in staff morale. She asked the University to reverse the layoffs and hire these workers back.
- B. Mr. Jaime Duran, senior hospital assistant at UC Irvine Medical Center, recounted that the layoffs had left him with a greater number of patients requiring constant and intensive attention and that there was a greater risk to patient safety due to understaffing. He asked the Regents to halt layoffs and bring these workers back.

2. APPROVAL OF MINUTES OF PREVIOUS MEETING

Upon motion duly made and seconded, the minutes of the meeting of October 18, 2016 were approved.

3. REMARKS OF THE EXECUTIVE VICE PRESIDENT – UC HEALTH

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

Executive Vice President Stobo began his remarks by expressing his confidence in the UC Health strategic plan, which had a solid underpinning and would remain stable in spite of the uncertainty caused by the recent U.S. presidential election. He briefly summarized discussions that had taken place at the UC Health leadership retreat on November 3-4. Topics included large-scale patient data study and analysis, reimbursement changes associated with the Medicare Access and Children's Health Insurance Program Reauthorization Act, greater academic collaboration among the schools of medicine, medical center leadership development, and UC Health's interactions with Kaiser Permanente.

Dr. Stobo reported on the ongoing study of the Market Reference Zones (MRZs) for health services senior management positions. The study aims to ensure that the compensation for these positions is market-competitive. UC Health had engaged the consultant Sullivan Cotter to provide background data and a working group would develop a plan that would be presented to the Committee in early 2017.

Dr. Stobo presented a financial summary for the first quarter of fiscal year 2017 with figures from the five medical centers for operating margins, days' cash on hand, and debt service coverage, compared with figures for the first quarter of fiscal year 2016. He expressed concern about softening of the operating margins in an environment of decreasing reimbursement. While UC Health had reduced its costs over the last several years by \$250 million to \$300 million, this was not sufficient. The previous year, revenues had increased by eight to nine percent, but year-over-year costs increased by 11 percent.

Regent Sherman asked if there had been any discussion of commercializing the large-scale data from all UC medical centers. Dr. Stobo responded that UC has discussed this in meetings with Google, Optum, and other organizations, who would like a proof of concept. As one example, UC has been using a Genentech cancer drug for some time, and Genentech would be interested in data from UC patients in order to better understand the efficacy of this drug.

Committee Chair Lansing stressed that this was an important future direction and that UC data could save lives and lead to cures for diseases. Dr. Stobo noted that other health organizations were also amassing useful data; if UC Health did not develop its data quickly enough, its data might become obsolete. Regent Sherman underscored the importance of UC Health acting as one system in order to achieve this.

Chair Lozano observed that some of the differences in figures shown for fiscal years 2016 and 2017 were significant. She asked about the University's assumptions regarding these variances, contributing factors, and whether the differences represented trends or one-time adjustments due to capital expansions. Dr. Stobo responded that this topic would be discussed in more depth at a future meeting. He observed that first-quarter data are often less favorable than data from the preceding year and stated his belief that the negative margins shown for UCSF and UC San Diego were one-time phenomena and that these medical centers would reenter positive financial territory. In the past, annual

increases in commercial contracts were eight or nine percent; currently they were at four percent. He recalled that commercial contracts account for 60 percent of UC Health's business. There would be continued pressures on Medicare and Medi-Cal, and this would be intensified with the new U.S. presidential administration. The pressures on revenue were enormous and relentless. He reiterated his concern that UC Health was not reducing its expenses fast enough.

UCSF Health Chief Executive Officer Mark Laret noted that some of UCSF's financial performance was related to expected changes, such as opening a new hospital, but that UCSF had not anticipated the disproportionate growth in Medi-Cal patient volume. About one-third of UCSF's business is in Medi-Cal, but it accounts for 15 percent of UCSF revenue, while commercial contracts account for about 40 percent of UCSF business but contribute about 60 percent of UCSF revenue. Mr. Laret remarked that most other providers in this marketplace have decided to limit the number of Medi-Cal patients they care for. Dr. Stobo added that UC Health has a Medi-Cal strategy, which he hoped would still be workable under a new U.S. presidential administration.

Regent Reiss asked if the Committee would receive a presentation on this Medi-Cal strategy, including the question of whether reimbursement could cover the cost of care, and if there would be discussion of UC Health's cost reduction plans, either by location or systemwide. She asked if UC Irvine had a reorganization plan following layoffs at its hospital. Dr. Stobo responded that these issues would be discussed in more detail at a future meeting. UC's Medi-Cal strategy had three parts: maximizing reimbursement for physician providers and hospitals, working with the State and with the Centers for Medicare and Medicaid Services; working with the major Medi-Cal managed care plans to develop full-service contracts that are beneficial for both UC Health and these plans; and more effectively managing the care of this population, so that cost of care better aligns with reimbursement. He noted that UC Health lost approximately \$700 million in the current year on care to Medi-Cal patients. Implementation of this three-part strategy would take place over three years. Dr. Stobo recalled UC Health's successful efforts so far to reduce costs in areas such as procurement and information technology. A new effort would focus on labor productivity. He expressed his view that cost reduction could best be accomplished at the systemwide level.

Regent Reiss asked if a financial plan would be presented to the Committee, noting that the systemwide cost reduction measures were not close to covering the \$700 million annual loss in reimbursement, and asked about cost reduction plans at individual locations. Dr. Stobo responded that by 2020 UC Health must reduce costs by \$1 billion, either systemwide or at locations. The University's program for increasing Medi-Cal reimbursement was scheduled to begin July 1, 2017.

Regent Reiss stated that UC Health should explain to the public the context of difficult decisions it must make, such as laying off employees. Dr. Stobo responded that no individual UC hospital can take an action regarding labor without affecting every other medical center. He stated that it would be appropriate for any of the medical center chief executive officers, when considering labor actions, to bring the matter forward for

systemwide discussion. Regent Reiss again suggested that the University should work on its communications strategy, in particular communicating about the health care it provides to Medi-Cal patients and underserved populations.

UC San Diego Health Chief Executive Officer Patricia Maysent remarked on the impact of non-cash items on UC Health financial statements. In the area of contract revenues, UC San Diego would need to trade a high-cost structure for more market share in the future. UCSD had added \$117 million to its expenses in opening the Jacobs Medical Center, but Ms. Maysent expressed confidence that the new hospital would provide financial growth. Like other UC medical centers, UC San Diego was reducing costs annually by between \$50 million and \$80 million.

Advisory member Dimsdale asked if UC Health affiliations would shift more Medi-Cal patients to UC inadvertently. Mr. Laret responded that UCSF was aware that it would receive more Medi-Cal patients through some of its affiliations. In response to another question by Dr. Dimsdale, he responded that UCSF tracks the payer and financial performance of each relationship.

Advisory member Lipstein observed that the degradation in margins shown for UCSD and UCSF were likely to be attributable to investments in new facilities or electronic health records systems. Medical centers would only have a sustainable advantage if they can offer a service that others cannot replicate. Mr. Laret noted that some of UCSF's facilities expenses were due to seismic safety requirements.

4. **UC HEALTH: REVIEW OF THE CLINICAL ENTERPRISE STRATEGY**

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

Executive Vice President Stobo began the discussion by stating that UC Health was seeking to increase its access to patients of all kinds, in particular patients with commercial insurance, and it was doing so in a highly competitive arena. This would be pursued through partnerships rather than by building new facilities. UC Health was the largest provider of tertiary and quaternary care in California, but it should increase its primary and secondary care activity as well. UC Health would increase its patient volume through three strategies. The first was an insurance strategy – ensuring UC has access to patients with commercial insurance and appropriate relations with commercial payers, and developing self-insured plans for which UC can better control the cost of premiums while keeping funds within the University. The second was a provider strategy, partnering with existing providers through acquisitions, affiliations, or other kinds of joint ventures. The third strategy was to add value to the care UC Health provides. Value was a complex formula including, cost, access, and quality.

More than 60 percent of UC Health revenue comes from commercial payers, and about 37 percent from public payers. For one dollar of care, commercial payers pay \$1.40. Dr. Stobo attributed this to these payers' belief that the value added by UC is worth this

extra expense and their wish to support UC's educational and research mission, but added that commercial payers were increasingly wondering about the value received for that \$1.40. Medicare pays roughly 90 cents per dollar of care, and Medi-Cal about 50 cents. In percentages, the patient volume for these two sources is the opposite of revenue: commercial contracts account for about 37 percent of patients, while public payers make up about 62 percent of patient volume.

In discussions with UC, commercial providers such as Blue Shield, Health Net, and Anthem have indicated that they plan to expand their third-party administrative services for other insurers. Dr. Stobo presented a list by health plan of annual revenue from commercial contracts, which are negotiated every three years. While each campus has a different rate, UC negotiates as a system, so that if there is not agreement among all the health sciences campuses and the insurer, no contract is agreed to. This has been an effective approach for the University to achieve fair rates. UC has developed strategic relationships with UnitedHealthcare and Anthem. UnitedHealthcare would be involved in UC's development of an Accountable Care Organization (ACO) and a self-insured product for large employers. Anthem would be involved in ACO development and telemedicine. UC did not plan to have strategic relationships with other payers. These contracts with UnitedHealthcare and Anthem would not be exclusive.

In response to a question by Regent Sherman, Dr. Stobo explained that UC's self-insurance and Kaiser Permanente were not included in this list. Kaiser was the largest provider of health care to UC employees.

Regent Sherman asked if negotiated rates for specific procedures can differ by campus. Dr. Stobo responded in the affirmative, noting that this may be due to differences in local labor markets.

Regent Sherman asked if UC Health compares these rates to the cost of providing services in order to determine which medical center has the best operating margin. Dr. Stobo responded that UC Health was not yet able to do this. He observed that a medical center might transfer costs from the inpatient to the outpatient arena to be more effective in competing for an inpatient contract. Due to this ability to move costs, academic medical centers do not entirely understand their costs.

Advisory member Lipstein remarked that there are strategic pricing opportunities in academic medical centers. There may be less competition in comprehensive cancer services than in maternity services, for example. In areas with less competition there is more price tolerance. Academic medical centers may price their tertiary and quaternary services higher than services for which there is more competition.

Regent Sherman asked what percentage of the business of these commercial providers in California was represented by UC. Dr. Stobo responded that UC was Anthem's first- or second-largest customer. He would provide this information. UnitedHealthcare was seeking to play a greater role in California, and this was their motivation for working with UC Health to make UC medical centers national centers of excellence.

Regent Sherman asked if there were different reimbursement rates for Medicare and Medi-Cal by campus. Dr. Stobo responded in the affirmative, but noted that these rates were within a tight range. UC Davis Health Chief Executive Officer Ann Madden Rice added that various cost factors and cost structures account for these differences. UCSF Health Chief Executive Officer Mark Laret noted that UCLA and UCSF receive less Medi-Cal reimbursement than UC Irvine, UC San Diego, and UC Davis.

Committee Chair Lansing commented on the general uncertainty about how Medicare and Medi-Cal would be affected by the new U.S. presidential administration. Dr. Stobo responded that the State of California would likely receive less federal funding.

Regent Sherman asked why reimbursement rates from Medi-Cal were so low, the fourth lowest in the nation. Mr. Lipstein explained that Medi-Cal eligibility thresholds were among the most generous in the U.S.

In response to a question by Regent Reiss, Dr. Stobo explained that individual UC hospitals receive a reimbursement rate based on the rate they charge. If one medical center charged \$100 for a service, UC Health might negotiate \$0.90 per dollar in reimbursement; if another medical center charged \$150 for the same service, UC Health might negotiate \$1.20 in reimbursement. UC San Diego Health Chief Executive Officer Patricia Maysent explained that local markets must be taken into consideration, since every market is different.

Regent Reiss asked if differences in reimbursement rates were also based on factors other than market factors. Dr. Stobo responded that each medical center was studying this matter. It is not possible for every medical center to charge the same rates; this would be price fixing.

Regent Reiss asked if UC hospitals were examining their pricing for tertiary and quaternary services versus primary and secondary services, as mentioned earlier by Mr. Lipstein. Ms. Maysent responded that the medical centers were constantly considering this. Capacity is an important factor in pricing various services. The directors of UC Health cancer centers and departments are working to identify services provided uniquely by UC, and how these can be marketed and priced. Dr. Stobo added that UC hospitals were seeking the lowest reasonable rate that would be competitive.

Mr. Lipstein noted that UC Health would have the flexibility to allocate resources provided by its contract with UnitedHealthcare among the medical centers. Mr. Laret stressed that each medical center operates in a slightly different market and that its prices must be competitive in that arena.

Regent Sherman recalled that about 60 percent of UC patient volume was in noncommercial payers and asked if UC had any say about those rates. Even a small increase in these rates would result in significant revenue. Dr. Stobo responded that there was some flexibility. He stated that reimbursement rates could be increased, and the

University was pursuing this goal, but this would depend on the State's relationship with the Centers for Medicare and Medicaid Services.

Dr. Stobo stressed that UC Health would tenaciously pursue increased reimbursement from Medi-Cal, but remarked that this alone would not solve the funding problem. In his view, UC would also have to manage care more effectively so that the cost of care was better aligned with reimbursement, and work with Medi-Cal managed care companies, who would take some risk. Increased reimbursement was only part of the solution.

Executive Director – UC Self-Funded Health Plans Laura Tauber explained that UC was moving increasingly toward self-funding its employee health plans. Beginning in 2017, the University would self-insure or take risk for about two-thirds of its employees. This was a beneficial approach both from an employer and a provider standpoint. As an employer offering a portfolio of health benefits, UC self-funds in order to have more control over the network, benefits, and cost and to be able to cap premium increases at no more than five percent annually. The cost is affordable and predictable for the University and its employees. The University can customize the benefits and plan design to best meet its needs, including encouraging employees to receive care by UC medical professionals, which keeps premium monies spent on services within the UC system. Self-funding offers the ability to enter into special relationships and partnerships that further UC goals and help control costs, and makes it easier to negotiate pharmacy discounts and rebates and hold a pharmacy benefit manager accountable for results. By pooling multiple plans for underwriting purposes, the University mitigates risk by spreading it over a larger membership.

As providers of care, UC medical centers have entered into ACO arrangements with several health plans to share risk. The medical centers' participation in the employee self-funded health plans provides a "test and learn" environment as they prepare to take on more financial risk in the future. In 2019 or 2020, UC anticipates offering a preferred provider product to the California market aimed at large self-funded employers. Among other benefits to the medical centers, this plan would allow the medical centers to take risks and partner with health plans for new products, and would encourage the development of new methods of financing and innovation in the delivery of health care.

Beginning in 2017, UC would offer three types of plans to its employees. Ms. Tauber reviewed these types, the self-insured preferred provider plans, the hybrid Blue and Gold plan, and fully insured health maintenance organizations. Through its self-insured plan, UC Care, the University encourages employees to use UC providers, offering lower out-of-pocket costs. From 2010 to 2015, the volume of medical services provided to UC employees at UC facilities increased from 25 percent to 38 percent, and the absolute dollars spent for services by UC providers more than doubled.

Dr. Stobo stated that by moving to self-insured employee health plans the University had better control over the premium, which would not increase by more than five percent per year. For example, if the actual cost of care increased by seven percent, UC Health would have to pay the difference; this circumstance compels UC Health to strive to keep cost

increases below that five percent limit. As a result of the UC Care plan, about \$500 million remained within the UC system rather than being paid to other providers. UC Health had set a goal that all its employee health plans, with the exception of Kaiser, should be self-insured by 2018.

Advisory member Dimsdale requested clarification of his understanding that the five percent cap was a limit for the University, not employees. Employees have concerns about the maximum out-of-pocket expenses in UC Care. Ms. Tauber responded that the five percent cap pertained to the amount UC spends to provide benefits to employees. When UC's actuaries first examined the question of setting rates, based on expected costs for the following year, they calculated the increase at about 11.5 percent, based on expected trends in pharmacy and medical costs. The University pursued an option of having a smaller number of participants pay their fair share for services, although the cost of the services was still highly subsidized. Dr. Stobo added that the amount of the employee contribution had decreased.

Chair Lozano referred to information presented about one of the health plans for UC employees offered through Western Health Advantage. Western Health Advantage appeared to be a small contributor, and the cost of administering this one provider could be high. She asked if the University were considering moving out of this arrangement. Dr. Stobo responded in the affirmative; discussions were taking place about such a move. This health plan at UC Davis does not cover the full cost of providing care. The campus has continued with this plan because many UCD employees are participants in it.

Regent Reiss asked how the five percent cap of UC Care compared with fluctuations with commercial insurers. Dr. Stobo responded that the ten-year average for commercial insurers is an annual increase of eight to nine percent. Regent Reiss asked how UC was able to lower the employee premium rate for UC Care, and if the employee out-of-pocket expenses were increasing. Ms. Tauber explained that the algorithm process used by Deloitte Consulting for determining the employee contribution was complex; an important factor was the differences in risk among plans – UC Care had the highest risk profile and Kaiser the lowest. The risk profile reflects the relative health or sickness of a population. The employee contribution is determined by pay band and by adjusting the risk profile. This year, after UC had submitted the five percent increase for UC Care, the algorithm process resulted in a decrease in the employee contribution, a result that could not have been anticipated or known in advance.

Regent Reiss asked if UC's self-insured plans were operating in the black. Dr. Stobo responded in the affirmative. Referring to the process for determining the employee contribution for UC Care, he noted that the University sets the five percent limit, but does not determine which proportion of the five percent increase is paid by the University. The University pays about 85 percent of the total cost of care, while the employee pays about 15 percent. The University does not determine the employee contribution. For this year, the actuarial analysis had suggested a rate increase of about 11 percent. The University addressed this by increasing the out-of-pocket deductible, because this would affect the smallest population and the population that uses the most care.

Regent Sherman asked if UC's self-insured plans included reinsurance. Ms. Tauber responded that the plans use Fiat Lux, the University's captive insurance company, for reinsurance. Regent Sherman remarked on the wide range of health plan options available to UC employees.

Mr. Lipstein reported that in Missouri, medical plan expenses for BJC HealthCare's 30,000 employees would increase by about 4.5 percent in 2017, while pharmaceutical expenses would increase by 9.9 percent. Pharmaceutical expenses were the fastest-growing component of most medical benefit plans.

Mr. Laret reflected on the challenge faced by UC medical centers of how to allocate resources. UCSF was a \$4 billion business which had managed \$80 million in cost reductions the prior year and was aiming for another \$80 million in savings this year. This might entail the elimination of positions at UCSF. He emphasized the importance of tertiary and quaternary care for UCSF's operating margins and noted that UCSF's competitors increasingly no longer refer these patients to UCSF, or, if they do refer tertiary and quaternary care patients, they are Medi-Cal or uninsured patients.

Mr. Laret outlined strategies for ensuring referrals of tertiary and quaternary patients: providing superior access, cost, and outcomes; building a primary care network; developing a clinically integrated network; partnering with large systems like Kaiser; affiliating with other hospitals; and forming one's own ACO. He commented on UCSF partnerships and affiliations, which take a variety of forms, with different degrees of integration and control, and different degrees of risk. UCSF has a process for evaluating potential partnerships with physician groups, hospitals, and other providers, including a prioritization scorecard and risk assessment. Mr. Laret outlined some of the evaluation criteria, which lead to an overall score for potential partnerships. Partnerships with other providers did not exist 20 years earlier but were now essential in order for academic medical centers to compete in the market, financially and academically. While all partnerships entail risk, UCSF was constantly evaluating these risks as opposed to the risk of inaction.

Dr. Stobo recalled that around 2009-10 the UC medical centers had engaged in a thorough discussion about their role, and had come to the conclusion that they could not focus only on providing tertiary and quaternary services, and that they must build networks and partnerships in order to remain competitive in the market.

Dr. Dimsdale observed that it is advisable to involve faculty at an early stage in developing programs and initiatives like those described by Mr. Laret, in order for them to have a good understanding of the impact affiliations will have on teaching programs. He asked if faculty are consulted about how new affiliations are staffed. Mr. Laret responded that the leadership of the UCSF School of Medicine and the Medical Center, including faculty, work together on these matters. In response to another question by Dr. Dimsdale, Mr. Laret asserted that UCSF would not pursue affiliations that would involve increased pension liabilities.

UCLA Health Sciences Vice Chancellor John Mazziotta reported that as UCLA Health has expanded geographically, some of its affiliation sites are managed by staff physicians who are not UCLA faculty and who have no teaching responsibilities. He anticipated that this situation would become more frequent. Staffing for UC's affiliation sites does not always require faculty.

Mr. Lipstein questioned why each health sciences campus needed to have its own prioritization scorecards and risk assessment methodologies. While recognizing differences in geography, a common, shared set of criteria would be helpful for the Committee. He asked if such a common methodology could be developed. Mr. Laret responded in the affirmative, stated that to some extent such a methodology had already been developed, and deemed this to be a timely and appropriate suggestion.

Ms. Rice noted that the UC medical centers have very different markets. UC Davis Health's primary goal in its outreach programs is to improve quality and access to care across its 33-county region, with a major focus on hospitals within a 50-mile radius. She enumerated other criteria and goals for strategic partnerships and described UCD's geographic service area, which is predominantly rural and has a population of about 6.3 million. She noted that there were no independent hospitals left in the system's local market of Sacramento and Yolo Counties. The three major competitors for UC Davis Health were Kaiser Permanente, Sutter Health, and Dignity Health. Ms. Rice outlined some strategies for contiguous growth within a 50-mile radius, including providing tertiary and quaternary care not available at community hospitals and using UC Davis' expertise and clinical resources to support specialty services at community hospitals. She described the telemedicine program and current affiliations and partnerships. UC Davis Health essentially works with all hospitals in its area.

Regent Reiss asked if consideration of financial benefits was among the criteria for evaluating affiliations. Ms. Rice responded in the affirmative. UC Davis considers financial factors and reputational risk.

Mr. Lipstein asked how the Committee could be certain that the various programs and initiatives enumerated by Ms. Rice were successful and achieving their objectives. Ms. Rice responded that UC Davis tracks the financial benefit of referrals and the market share related to growth and quality.

Mr. Lipstein suggested that a dashboard or scorecard for evaluating the relative success of affiliation strategies would be helpful for the Committee and for the medical centers. He observed that new affiliations are usually not entirely successful from the start. Problems must be solved over time. With retrospective examination, it is helpful to see which problems arose right after the beginning of an affiliation.

Chair Lozano reflected on UC Davis' broad reach in the north of the state and the Central Valley. She asked if there were a master planning consortium that operates collectively, looking at the broader context of California healthcare needs, so that UC Davis does not try to fill every need but offers services other providers cannot offer, in a complementary,

planned way. Ms. Rice responded that UC Davis' cancer care network was a good example of this, working at other providers' sites. UC Davis works with the Hospital Council of Northern and Central California to gain an understanding of existing needs and has had a strong relationship with Adventist Health, working on health needs in rural areas.

Regent Sherman noted UC Davis' panoply of various kinds of collaborative relationships. He asked in which areas UC Davis Health excelled, and how this was maximized through UC Davis' affiliations. Ms. Rice responded that areas of emphasis for UC Davis Health were pediatric care, cancer care, and neurosciences. UC Davis has chosen not to offer some services, such as liver transplants, partnering with UCSF instead.

UCLA Health President Johnese Spisso discussed UCLA's strategies for adding value to health care in four areas: change in organizational culture, creating infrastructure needed to support value, educating UCLA's entire healthcare team on value and the new value-based environment, and showing leadership on and a commitment to transparency with payers around shared goals in risk-based contracts. UCLA was seeking to improve patient outcomes and satisfaction as well as to reduce the total cost of care. Patients and plans interpret value differently. UCLA Health endeavors to see value through the lens of the patient.

UCLA's efforts to add value take into account population health management in the ambulatory setting, clinical care improvement and care transformation projects, and patient experience enhancement. UCLA tries to measure outcomes and costs for every patient and provide timely information to care providers. Payers and purchasers wish to see population-based integrated care models, multi-channel access, and care coordination. Large employers would like behavioral health to be integrated in their plans. UCLA is constantly working to improve its data, such as claims data. This helps one to understand how UCLA Health is perceived by payers and how UCLA should explain services that appear to have high costs. Employers also wish their employees to have access to clinics within 30 minutes of their residence, and to have same-day access when needed. UCLA has worked to expand its reach into communities with its primary care clinics. UCLA Health was currently operating in 160 clinics in 75 locations in Greater Los Angeles. Out of 320,000 patients, about 200,000 were in some type of risk-based agreement.

Ms. Spisso described UCLA's primary care innovation model, including the integration of behavioral health and advanced care planning, especially for patients in cancer care and organ transplantation programs. UCLA tries to begin palliative care in the outpatient setting. Publishing the outcomes of behavioral health care demonstrates the value of this care to plans and employers.

UCLA Health adds value to the patient experience through training in all its clinics for all physicians and care team members, sharing transparent patient satisfaction data with the clinics every month, and dispatching an ambulatory resource team. Ms. Spisso presented a chart showing significant improvements in clinic wait times and patient experience with clinic staff.

Unlike patients in Health Management Organization contracts, patients in ACOs are not required to receive all covered services within the contracted system. UCLA was reviewing its post-acute care and rehabilitation therapy strategies, to ensure that when patients receive services outside UCLA, these outside providers will work with UCLA and help to bring costs down.

UCLA Health has focused on factors that contribute to the total cost of care – acute care, observation and extended recovery care, outpatient facilities, and pharmacy costs. Ms. Spisso presented a list of ACO criteria and activities and corresponding UCLA operational initiatives to be deployed to bring about improvements in these areas.

Ms. Spisso noted some trends in the UCLA Anthem ACO's quality and financial performance in 2014 and 2015, such as an improved quality score. In 2014, UCLA Anthem ACO reduced the total cost of care by \$4.3 million and in 2015 by \$6.3 million. UCLA has found that it can bend the cost curve through care management. Anthem had also begun to negotiate care management fees with employers who have Anthem contracts. She then presented some 2016 figures for the UCLA Health Net ACO, which had saved \$2.73 per member per month to date in the current year.

Dr. Stobo noted that all the UC medical centers were engaged in quality initiatives like those at UCLA. Best practices and quality indices are shared systemwide.

Regent Sherman suggested that some of these statistics shown for UCLA be presented for UC Health systemwide by medical center. Dr. Stobo responded that this information would be provided. Overall, UC shares risk evenly with Health Net: for UC providers UC is responsible for 70 percent, while Health Net is responsible for 30 percent; for outside providers, UC is responsible for 30 percent, while Health Net is responsible for 70 percent. The University had data by medical center on savings per member per month.

Mr. Lipstein asked how the improvements in quality and reductions in cost, which one expects to produce a favorable financial outcome for UCLA, could be reconciled with UCLA's operating margin degradation shown on a slide in an earlier presentation. Ms. Spisso responded that the financial statements were affected by accounting for post-retirement benefits. The information for patients in the ACOs did not apply to all UCLA patients. The results for the top ten diagnosis-related groups of Medicaid patients differed greatly from those for the top ten diagnosis-related groups of commercially insured patients. UCLA had significant losses in this Medicaid area.

Dr. Stobo stated that the degradation in margins was a gross measure. The savings UC Health has been able to accrue in examples involving relatively small numbers of patients are outweighed by other impacts on UC Health financial statements, such as the impact of pension contributions and other post-employment benefits. He estimated that the pension obligation was roughly 50 percent a current cash obligation and 50 percent a future liability. Dr. Mazziotta agreed, stating that the benefit and pensions obligation would dwarf these savings.

5. OPERATING PARADIGMS FOR THE FUTURE OF UC HEALTH

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

Executive Vice President Stobo began this discussion by relating that UC Health was seeking a paradigm that would define the relationship of the central administration of UC Health at the Office of the President to the health sciences campuses. The Star Alliance in the airline industry might provide such a paradigm. He enumerated similarities between the healthcare and airline industries, such as safety-consciousness, competition, regulation, a unionized workforce, and the desire to cut costs. He described the 1994 origins of the Star Alliance as a cost-cutting initiative by a number of airlines that began with group purchasing. The Star Alliance had since grown to 28 airlines, with shared purchasing, marketing, reservations, and customer mileage programs. The Star Alliance does not infringe on the identity of any of its individual airlines, but holds them to certain standards. Member airlines are audited annually on these standards with significant fines for noncompliance.

Dr. Stobo stated his view that the Star Alliance was an interesting paradigm but that UC Health needed to work more as a system than Star Alliance. He presented contrasting definitions of the terms “alliance” and “system.” One definition of an alliance is “an association to further the common interests of the members.” A system, on the other hand, can be defined as “an organized, purposeful structure that consists of interrelated and interdependent elements... These elements continually influence one another (directly or indirectly) to maintain their activity and the existence of the system, in order to achieve the goal of the system.” Using these definitions, UC Health was somewhere on the spectrum between being an alliance and a system. He reviewed some of the benefits individual medical centers and providers derive from being part of UC Health.

Chair Lozano observed that the medical center chief executive officers must be the driving force for change in this direction. Faculty and patients also benefit from UC Health working as a system. The University should identify key stakeholder groups and provide an incentive for them to move toward working as a system. Dr. Stobo responded that UC Health had focused mostly on patients but needed to do a better job of demonstrating to faculty that they benefit by being part of UC Health.

Committee Chair Lansing stated that patients should be made aware of the benefits of UC Health, such as the sharing of research results.

UCSF Health Chief Executive Officer Mark Laret emphasized financial factors as a motivation for change. He recalled that UC Health clinical activity accounts for about one-third of the University’s operating budget. The system approach was necessary.

Advisory member Dimsdale expressed support for directly involving faculty, who can identify great potential savings. Mr. Laret observed that saving money was an imperative in order to maintain the status quo.

Advisory member Lipstein anticipated that UC Health, in moving toward being a system, would soon arrive at a major juncture. Most of the economic benefit to UC Health members accrues to the expense side, through sharing of costs. The question now was whether UC Health members would ever share revenue, which would represent a major change. In health systems like Kaiser Permanente, revenues are shared and allocated by a leadership group. UC Health would likely arrive at this key decision point sooner than it wished due to the challenging revenue situation. Dr. Stobo agreed that this would occur in the next few years. In order to maximize Medi-Cal and Medicaid income, it might happen that an advantaged campus would have to help a disadvantaged campus. The actions of one health sciences campus have ripple effects felt by all the others.

The meeting adjourned at 1:40 p.m.

Attest:

Secretary and Chief of Staff

Pending Approval