

The Regents of the University of California

**COMMITTEE ON HEALTH SERVICES**

February 3, 2016

The Committee on Health Services met on the above date by teleconference at the following locations: Covell Commons, Los Angeles campus, and Punta Mita, Ramal Carretera Federal 200 Km. 19, Bahía de Banderas, Nayarit, Mexico.

Members present: Regents Lansing, Makarechian, Reiss, and Sherman; Ex officio member Napolitano; Executive Vice President Stobo, and Chancellors Hawgood and Khosla

In attendance: Secretary and Chief of Staff Shaw, General Counsel Robinson, Vice President Duckett, and Recording Secretary Johns

The meeting convened at 12:15 p.m. with Committee Chair Lansing presiding.

Committee Chair Lansing welcomed the attendees to the first meeting of the restructured Committee on Health Services. This was an outstanding opportunity to enhance the discussion concerning challenges faced by the UC Health clinical enterprise. This change in governance came at an opportune time, given the challenges UC clinical enterprises face in the environment of the Patient Protection and Affordable Care Act.

1. **PUBLIC COMMENT**

There were no speakers wishing to address the Committee.

2. **APPROVAL OF APPOINTMENT OF AND COMPENSATION USING NON-STATE FUNDS FOR PAUL A. STATON AS SENIOR VICE PRESIDENT – FINANCE AND CHIEF FINANCIAL OFFICER, UCLA HEALTH, LOS ANGELES CAMPUS AS DISCUSSED IN CLOSED SESSION**

Recommendation

The President of the University recommended that the Committee on Health Services approve the following items in connection with the appointment of and compensation using non-State funds for Paul A. Staton as Senior Vice President – Finance and Chief Financial Officer, UCLA Health, Los Angeles campus:

- A. Appointment of Paul A. Staton as Senior Vice President – Finance and Chief Financial Officer, UCLA Health, Los Angeles campus at 100 percent time.
- B. Per policy, an annual base salary of \$620,000.

- C. Per policy, continued eligibility to participate in the Clinical Enterprise Management Recognition Plan (CEMRP) with a target award of 15 percent of base salary (\$93,000) and a maximum potential award of 25 percent of base salary (\$155,000). Actual award will be determined based on performance against pre-established objectives.
- D. As an exception to policy, continued eligibility to receive an annual performance-based retention incentive payment of ten percent of base salary for calendar years 2015 through 2017, based on the base salary in effect as of each December 31 (for a total of three payments) and payable in January of the following year if Mr. Staton meets the following requirements:
  - (1) He meets or exceeds performance expectations, as determined by the Chancellor (or his designee) and the Executive Vice President – UC Health.
  - (2) He continues leading the Executive Revenue Cycle Steering Committee initiative.
  - (3) He is actively employed as Senior Vice President – Finance and Chief Financial Officer, UCLA Health, on December 31 to receive that year’s payment. This is an exception to policy because there is no policy governing retention incentive payments.
- E. Per policy, continued monthly contribution to the Senior Management Supplemental Benefit Program.
- F. Per policy, continued eligibility to participate in the UC Home Loan Program, subject to all applicable program requirements.
- G. Per policy, continued standard pension and health and welfare benefits and standard senior management benefits (including senior management life insurance and executive salary continuation for disability).
- H. This action will be effective upon approval.

#### Background to Recommendation

The President of the University recommended approval of the appointment of and compensation for Paul A. Staton as Senior Vice President – Finance and Chief Financial Officer, UCLA Health, Los Angeles campus, at 100 percent time, effective upon approval. Funding for this position will come exclusively from non-State funds. This is a new, consolidated role at UCLA Health, combining financial oversight for the School of Medicine along with Mr. Staton’s current oversight of the Faculty Practice Group and the UCLA Hospitals. The new title is intended to reflect the expanded scope of Mr. Staton’s new role and align with other similar roles in the market.

In conjunction with the transition of leadership and the vision of the newly appointed Vice Chancellor for UCLA Health Sciences John Mazziotta, M.D., Ph.D., the strategic direction for the organization is to create a unified decision-making function to oversee the financial aspects throughout the UCLA health organization. This will allow the flexibility to respond to the healthcare environment that is expanding through acquisitions and affiliations, while benefitting from economies of scale. Thus, UCLA Health can remain competitive and responsive to the changing landscape in the healthcare industry, both locally and through its obligations and commitments under the Patient Protection and Affordable Care Act.

Mr. Staton's expanded role will incorporate the four Hospitals (Ronald Reagan UCLA Medical Center, UCLA Medical Center – Santa Monica, Resnick Neuropsychiatric Hospital, and Mattel Children's Hospital), the Faculty Practice Group (including 165 clinic sites with more than 1,200 full-time faculty physicians) and the UCLA David Geffen School of Medicine. Mr. Staton's responsibility is to oversee the successful financial performance and integration of financial perspectives of all entities under this umbrella.

Mr. Staton has served as Chief Financial Officer for the UCLA Hospital System since early 2005. UCLA Health System has undergone leadership reorganization aimed at positioning UCLA capabilities toward needed strategic growth and expansion of its clinical programs, particularly through the acquisition of community practices, clinics, and healthcare entities. As the organization continues to integrate the components under Vice Chancellor and Dean John Mazziotta, M.D., Mr. Staton will assume oversight for the entire UCLA health enterprise.

In Mr. Staton's role as Senior Vice President – Finance and Chief Financial Officer, he will have the following additional responsibilities:

- Serve as a core member of the UCLA Health senior executive leadership team, including the strategic planning and various councils to shape UCLA Health policy across entities, by aligning strategic priorities with system goals and objectives and adjudicating complex issues facing the system.
- Be responsible for the financial management of these entities, including financial planning, capital planning, budgeting, accounting, financial reporting, reimbursement, revenue cycle, financing, and design and operation of internal control systems.
- Assume oversight for UCLA Health Risk Management Services as well as UCLA Health system Materials Management and Logistics.
- Participate in formulating, communicating, and implementing strategic plans and institutional policies in compliance with University, State, and federal standards and requirements, balanced with best practices for efficiency and future vision.
- Lead key initiatives, both on the local level and through the UC systemwide committees, which include chairing the Revenue Cycle Steering Committee Initiative, chairing the UC Leveraging Value from Scale Executive Steering Committee, and various capital planning and operations work teams.

- Integrate financial operations throughout the various entities in UCLA Health. This position will have a direct reporting structure to Vice Chancellor – Health Sciences and Dean, School of Medicine, UCLA Health Sciences.

For this expanded role, the staff reporting to Mr. Staton will increase from 431 to more than 1,000. The budget responsibility under his purview will be approximately \$3 billion. Mr. Staton's extensive experience in healthcare finance will help the organization in the integration of the various groups toward a model of efficient, streamlined operations.

The President proposed an annual base salary of \$620,000, reflecting an increase of 15.7 percent, for the appointment of Mr. Staton to this new, expanded role. Mr. Staton's current salary is \$535,990. The proposed salary is approximately 6.9 percent above the 75th percentile and below the 90th percentile of the Market Reference Zone (MRZ), properly reflecting the scope of Mr. Staton's responsibilities, his specialized credentials (including certified public accountant), track record of performance, and his depth of expertise, and is consistent with Regents Policy 7701, Senior Management Group Appointment and Compensation. This MRZ is in use for similar positions at UC Davis, UC San Diego and most recently, UC San Francisco where the financial oversight has been expanded to include the School of Medicine in addition to the health system.

Mr. Staton will continue to lead the systemwide Revenue Cycle Initiative. The Executive Revenue Cycle Steering Committee initiative commissioned by Executive Vice President Stobo and resulting from the UC "Value from Scale" Revenue Cycle review focuses on the development and implementation of opportunities for improved financial and operational performance for all UC hospitals, thereby creating greater integration throughout the University. The effort to build a top industry model of integrated revenue is being spearheaded by Mr. Staton, with a target savings of annual recurring cash flow between \$122 million and \$148 million. This three-to-five year optimization and standardization effort led by Mr. Staton will deliver opportunities for performance improvement and develop strategic direction, functional decision-making, and tactical implementation activities across the UC system. For this additional systemwide role, Mr. Staton will continue to receive an annual payment of ten percent of annual base salary in effect as of each December 31, ending in 2017. Funding for this position is entirely from non-State funds, specifically UCLA Health revenues.

The compensation described above shall constitute the University's total commitment until modified by the Regents, the President, or the Chancellor, as applicable under Regents policy, and shall supersede all previous oral and written commitments. Compensation recommendations and final actions will be released to the public as required in accordance with the standard procedures of the Board of Regents.

[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.]

UCLA Vice Chancellor John Mazziotta explained that the proposed appointment reflected a new governance approach to UCLA Health's finances. The proposed Senior

Vice President – Finance and Chief Financial Officer, Mr. Paul Staton, would receive an increase in compensation and would assume an increased scope of work, overseeing the entire medical enterprise at UCLA, including the hospital system, the Faculty Practice Group, and the School of Medicine. Mr. Staton was qualified for this position, based on his record of performance, depth of expertise, and special credentials. This appointment would provide a consolidated role that would allow integrated financial decision-making across the organization. Mr. Staton was an ideal individual to lead in that capacity. The funds to cover his salary would come from clinical revenue and the appointment would not involve any new, additional hires.

Regent Reiss emphasized that the proposed appointment was well within the University's parameters for appointments and compensation, including the Market Reference Zones.

Upon motion duly made and seconded, the Committee approved the President's recommendation, Regents Lansing, Makarechian, Napolitano, Reiss, and Sherman voting "aye."<sup>1</sup>

### 3. **REVIEW OF RESPONSIBILITIES FOR MEMBERS OF THE REGENTS COMMITTEE ON HEALTH SERVICES**

[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.]

Executive Vice President Stobo referred to the appointment and compensation action just taken. He anticipated that there would be other similar actions, consolidation of financial responsibilities under a single position, at other UC campuses with medical schools, hospitals, and physician practice plans. This was a prudent and important move so that UC's clinical enterprise has a grasp of all its financial operations.

Dr. Stobo reviewed the parameters of the reconfigured Committee on Health Services. The Committee has 15 members, seven voting members and eight non-voting members. The seven voting members are the Governor, the President of the University, the Chair and Vice Chair of the Committee, and three other Regents representing the Committees on Grounds and Buildings, Finance, and Compensation. The non-voting members include the Executive Vice President – UC Health, two chancellors, a member of the Academic Senate, and four outside advisors. Dr. Stobo reported that he had identified four outstanding individuals to serve as outside advisors. These had been reviewed by the President, the Chairman of the Board, and the Chair and Vice Chair of the Committee. The four individuals had agreed to serve if asked. One of them was the chief executive of a healthcare system associated with a private institution, another was the chief executive officer and the dean of a school of medicine, the third was a senior executive of a foundation, and the fourth represented a foundation with a national reputation in the area of healthcare policy.

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<sup>1</sup> Roll call vote required by the Bagley-Keene Open Meeting Act [Government Code §11123(b)(1)(D)] for all meetings held by teleconference.

The Committee on Health Services exercises primary jurisdiction, approval authority, and has an advisory role. One of its primary responsibilities is to develop a strategic plan for the UC clinical enterprise including budgetary and financial aspects. A strategic plan was to be presented to the full Board of Regents in July. Another activity of the Committee is to work with UC clinical enterprise leadership to develop assessments of the cost and quality of health care provided by UC Health, and to hold appropriate individuals accountable for meeting relevant criteria. The Committee is also responsible for reporting to the Board of Regents actions taken under delegated authority, either by the Committee, the President, or chancellors. Dr. Stobo stated that he would also update the Committee on managed care contracts. He would begin work on a report on student health centers and the Student Health Insurance Plan and anticipated that this report would be presented to the full Board in the summer. The work of the Committee is an exciting challenge and would benefit the UC clinical enterprise.

President Napolitano asked Dr. Stobo if he would need additional staff to accomplish this work. Dr. Stobo responded that his office would establish a position devoted specifically to developing and preparing materials for the Committee. His office would coordinate its work with the Office of the Secretary and Chief of Staff to The Regents.

As an example of the new coordination that needed to be developed, Chancellor Hawgood cited the item he would discuss later in the meeting about a new building at UCSF. This item had already been presented at the January Regents meeting. Committee Chair Lansing responded that this had occurred because the UCSF item arose during the transition to the new Committee structure. This kind of duplication would be avoided in the future.

4. **UC HEALTH: REVIEW OF PAST PERFORMANCE AND PRIORITIES FOR FISCAL YEAR 2016**

[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.]

Executive Vice President Stobo began the discussion by emphasizing that there would be significant challenges facing UC Health over the next several years. UC Health needs to work as one integrated, coordinated body to address these challenges. The signing of the Patient Protection and Affordable Care Act (or Affordable Care Act) in March 2010 by U.S. President Obama codified changes in the healthcare environment. Dr. Stobo expressed his view that many current developments were not precipitated by the Affordable Care Act but had begun earlier. Nevertheless, the Affordable Care Act represented a tipping point. The U.S. has moved from a healthcare environment characterized by entitlement to one with more accountability for quality, outcomes, safety, and costs.

One characteristic of the current healthcare environment is consolidation. The number of insurers in the State of California had decreased from about 12 to six over a period of three to four years. Another characteristic is competition among providers in areas like

quality and cost, which would be beneficial for health care. A third characteristic is cost reduction efforts by healthcare providers. A major impetus for the Affordable Care Act and changes in the healthcare industry are the yearly increases in the cost of health care in the U.S., increases that cannot be sustained.

“UC Health” refers to the activities of the five UC medical centers, including 11 hospitals, and 17 health professional schools located on seven campuses. UC Health is impressive not only in size but in breadth and quality. Considering size relative to net patient revenue, UC Health is the 11th largest public hospital system in the U.S. In California, Kaiser Permanente is the largest public health system by size and revenue, followed by Dignity Health, Sutter Health, and UC Health in fourth place. Because it is not only a provider but also a health plan, Kaiser has much greater net patient revenue than Dignity, Sutter, and UC Health. Nevertheless, UC Health is a large system in terms of numbers, net patient revenue, and other criteria. UC Health plays a significant role in delivering health care to medically underserved populations, those covered by Medi-Cal and those without health insurance. With the Medi-Cal expansion in California following the Affordable Care Act, UC has been serving an increasing number of patients with this insurance. Medi-Cal’s reimbursement rate for the cost of providing care is about 50 cents per dollar of cost. UC recovers about 90 cents per dollar from Medicare, and \$1.40 to \$1.50 per dollar from commercial insurers. The commercial insurers are supporting the provision of care to other patients, especially Medi-Cal patients.

UC Health has enjoyed financial success. Net patient revenue over fiscal years 2013, 2014, and 2015 grew 27 percent. In 2014-15, net patient revenue was \$9.27 billion. In budget terms, over the past seven years, UC overall grew 1.3-fold, while UC Health grew 1.9-fold. UC Health is not only a large part of the University, but it is growing at a faster rate than UC overall. Sixty percent of net patient revenue comes from commercial contracts. Medicare and Medi-Cal are smaller but still significant sources of revenue. All UC medical centers have strong operating margins, which provide the means to capitalize clinical facilities and programs and support programs in the schools of medicine. Annually, approximately 50 percent of the medical centers’ margins support medical school programs, so the financial strength of the medical centers is critical for the success of the schools of medicine.

Capacity is a major challenge for UC Health. All UC hospitals are full. UC emergency departments are often full and must alert ambulances to take patients elsewhere. The University is seeking to increase capacity quickly and cost-effectively.

UC Health’s ratings in the debt market are all very strong. From fiscal year 2014 to fiscal year 2015 net patient revenue increased by 11 percent, but expenses increased at a greater rate, by 12 percent. Part of the reason for this was increased expenses experienced by UCSF in opening the Mission Bay hospital. The medical centers’ financial contribution to UC programs outside the medical centers, such as the medical schools, increased by 19 percent. This was a demonstration of the medical centers’ commitment to these programs.

Dr. Stobo then discussed the forecast for revenue and expenses. For the past several years, UC Health had enjoyed a nine percent increase annually in its managed care contracts. Over the coming two years this was projected to drop to five percent and then to four percent. This projection was being borne out; UC was currently negotiating large managed care contracts with year-over-year increases of 4.5 percent to five percent. He referred to a chart that plotted this rate of reduced revenue growth against a nine percent annual increase in expenses, a reasonable projection given historical rates of increase. The chart took into account expense reduction activities UC Health was now embarking on which reduce annual expenses by roughly \$250 million. Even with these activities, expenses would begin to exceed revenues in about 2019. A nine percent annual increase in expenses was problematic. Dr. Stobo emphasized that the University must reach a position where expenses increase no more than four percent annually. No matter how effectively individual medical centers reduce costs, UC Health could only attain this goal by working as a system.

Labor costs accounted for about 55 percent of UC Health expenses. These costs would have to be addressed over the next several years. The next largest expense category was supplies and purchased services. Pharmaceutical expenses accounted for 30 percent of that category. From fiscal year 2014 to 2015 there was a \$100 million increase in pharmaceutical expenses, over a base of \$500 million. This was the largest increase in any category of supplies and due in large part to the increased cost of specialty drugs. Information technology expenses accounted for another 15 percent of the supplies category.

Dr. Stobo remarked on the success of UC Health's Leveraging Scale for Value project, which aims to save \$200 million to \$250 million annually. He presented a chart displaying net savings in various categories, savings minus the cost of implementing this program. For the first six months of fiscal year 2016, UC Health had achieved 69 percent of its goal. Cost reduction efforts were going well, but UC Health must do more.

UC Health currently had contracts with six major commercial healthcare providers: Anthem, Blue Shield, Health Net, Aetna, United, and Cigna. UC had recently signed a three-year contract with Anthem, worth \$1.6 billion annually, a three-year contract with Blue Shield for \$670 million a year, and a one-year contract with Health Net worth \$511 million. A three-year contract with Aetna was to be signed the following week, worth \$476 million a year. Negotiations were progressing with United Health for a three-year contract worth \$680 million. The United Health contract would be beneficial to the UC system. These contracts represented 60 percent of UC Health's net patient revenue. The multi-year contracts included an annual increase in a range of 4.3 to 4.7 percent. They were an essential element of UC Health's revenue.

UC was moving from having employees' health plans insured by commercial carriers to self-insurance plans. Dr. Stobo outlined reasons for this move. UC believes it can do a better job managing health care and maintaining the cost of premiums at a predictable low level if UC insures a plan and takes the financial risk. UC Health made a commitment to President Napolitano that the premium of any self-insured UC plan would



not increase by more than five percent a year. In the first year, UC Health was not able to keep this promise, but it was successful in the second year. With self-insurance, UC would have greater latitude in the benefit design and could develop better benefit packages for employees. Self-insurance would allow the University to keep its money in the UC system.

The overall cost to UC for employee health insurance was \$1.5 billion. Before UC began its self-insurance program, roughly 20 percent of that amount remained within the UC system, while 80 percent went outside UC. The two self-insured plans, UC Care and an arrangement with Health Net like a self-insured HMO, have changed this equation so that roughly 40 to 43 percent of the monies in those two plans stay with UC providers. Every one percent of this money that remains within UC amounts to \$10 million for UC hospitals and physicians. A portion of the margin generated by this income goes to support UC medical school programs.

In conclusion, Dr. Stobo discussed the current trajectory of UC Health, which is moving from five independent academic medical centers to five coordinated integrated academic health systems. He briefly outlined five stages of this process toward UC Health integration, which would advance local and collective strategies for cost, quality, and outcomes. He described UC Health over the past seven years as being in a position of strength and able to meet the challenges of the Affordable Care Act.

Committee Chair Lansing remarked that the reconfiguration of the Committee on Health Services was not a reaction to the Affordable Care Act but had been under discussion for several years. She asked if there were more opportunities for cost-cutting and sharing of services and supplies among UC medical centers, and opportunities to negotiate more favorable contracts. Dr. Stobo responded that sharing of services had begun, for example for the performance of liver transplants in northern California. This was a relatively difficult goal to reach, but Dr. Stobo felt that there was now more agreement among the medical center chief executive officers (CEOs) on the need for service sharing. It was necessary to ensure that UC has the data to identify where clinical service adds the most value, is performed with the highest quality and in the most cost-effective way. For some areas these data are easy to obtain, in others not. UC must also remain mindful that it is not only a clinical enterprise but an educational enterprise. Medical students, house staff, and fellows need to be exposed to the full breadth of clinical material, and this requires that students be able to receive training in locations where a particular procedure is performed.

Committee Chair Lansing observed that drug costs were a problem for every healthcare group. She asked about possible UC actions to address the enormous cost of certain life-saving medications, such as advocacy or partnering with other institutions. UC could be a powerful advocate in this matter and effective in enlisting the support of others. Dr. Stobo responded that this was a national problem with no easy solution. There would be further and more detailed discussion of this by the Committee in the coming months.

President Napolitano referred to the UC Health strategic plan to be presented in July. UC trains 50 to 60 percent of the physicians in California. Medical coverage is spotty in some parts of the state. UC needs to develop a strategy to address this need for physicians and other health professionals in underserved areas. Dr. Stobo responded that this would be included in UC Health's strategy. UC's medical and health professional schools need to be part of the solution.

Committee Chair Lansing cited UCLA's partnership with the Martin Luther King Hospital in Los Angeles as an example of UC working in underserved areas. She asked if this model could be duplicated elsewhere. Dr. Stobo responded that rationalizing the location of UC clinical services was a critical task and one for which the Committee could provide direction.

Regent Reiss referred to the financial forecast chart with its estimate of when UC Health expenses would begin to exceed revenue. She asked how the University would address healthcare labor costs. She cautioned that lower salaries might result in loss of quality. Dr. Stobo responded that UC has been studying relevant benchmarks. Consolidation was one way UC Health would address this issue, for example in procurement, as other health systems have done. Some industry benchmarks indicated that UC Health had too many employees at the managerial level.

Chancellor Khosla also referred to the financial forecast chart. He asked if the medical centers' contributions to the schools of medicine were calculated as a constant percentage. Dr. Stobo responded in the affirmative.

Chancellor Khosla expressed concern that UC Health might consider reducing contributions to the schools of medicine when expenses exceed revenue, or even before that point. As a system, the UC schools of medicine are among the highest-rated in the country. The University must remain cognizant of this and not cause a reduction in quality. Dr. Stobo stressed the University's desire to maintain the quality of its schools of medicine; it would not make sense for UC medical centers to only provide care and not to support the UC medical education programs. Committee Chair Lansing added that UC Health was seeking efficiencies in order to preserve this quality.

Regent Sherman requested data on operating margins by medical center. The University should learn from each medical center that was performing well and from others that were not performing as well. The data would show revenue generated in relation to number of patients served, recognizing that the medical centers have different capacities. Dr. Stobo responded that these data would be provided.

Regent Sherman asked what had been learned from these and other medical center financial data. Dr. Stobo responded that UC Health was identifying and disseminating best practices. One example was revenue cycle management, identifying how a particular medical center collects the revenue it reasonably should collect. Once these management practices are spread, the system might save \$120 million to \$140 million.

Regent Sherman asked if there was any beneficial practice at one medical center that could not be replicated at other medical centers, and if the Committee could assist with this in any way. Dr. Stobo responded that payer mix is of critical importance. Sixty percent of UC Health revenue comes from commercial insurers. Regent Sherman observed that this had been consistent over the previous three fiscal years. Dr. Stobo confirmed this but added that there had been an erosion of this percentage and an increase in Medi-Cal at some medical centers, which is financially challenging for these medical centers. One factor beyond control is the volume of patients needing emergency services, which accounts for a large percentage of admissions. UC can work to take more effective care of these patients and bring the cost closer to the reimbursement level. Some healthcare providers in California deliver care to Medi-Cal patients more effectively than UC and come closer to the reimbursement rate of 50 cents per dollar. UC may not be able to change the payer mix of Medi-Cal vs. commercial patients, but it can learn to deliver care to the Medi-Cal patient population more effectively.

Committee Chair Lansing remarked on the collegial feeling among chancellors and medical center CEOs and their willingness to cooperate as a system. It went without saying that the University would never compromise on the quality of its health care.

Regent Makarechian referred to a chart showing the operating income of the UC medical centers for fiscal years 2013, 2014, and 2015. He asked why the operating income at UCSF in those three years had fluctuated from \$7 million to \$159 million to \$69 million. Dr. Stobo responded that the opening of the Mission Bay hospital accounted for this fluctuation. Three factors increased costs. UCSF began servicing the debt and borrowed money, there was depreciation, and there was an increased cost of hiring labor for the hospital. Fortunately, occupancy in the new hospital increased faster than projected.

Regent Makarechian asked why the UC Davis Medical Center showed negative operating income for fiscal year 2013. Dr. Stobo responded that this was due to costs associated with pension expenses. Regent Makarechian asked why the other medical centers did not experience negative operating income. Dr. Stobo responded that the other medical centers' margins could accommodate these expenses. President Napolitano added that UC Davis was in litigation with the County of Sacramento for reimbursement for services provided to Medi-Cal patients. This was also affecting UC Davis' finances.

Regent Makarechian stated his understanding that the requirements for days' cash on hand for the medical centers was a minimum of 60 days, but another chart indicated that UCSF had only 53 days' cash on hand as of June 30, 2015. Dr. Stobo explained that when a medical center reaches the level of 60 days' cash on hand, this triggers an inquiry by UC Health about the campus' management plan to address the situation. In this case, UC Health felt certain that this was a temporary reduction and a one-time issue, not an indication of something irreversible. He stated that UCSF would soon return to the 60-day threshold.

Regent Makarechian asked about the financial feasibility of the new Neurosciences Research Building, the following item to be discussed. Chancellor Hawgood responded that the new building would be an expense of the campus, not the health system.

Chancellor Hawgood referred to the stages of the UC Health trajectory, outlined earlier by Dr. Stobo. In the fifth stage of the trajectory, UC Health would become a “system of systems.” Success in this stage would include integrated data systems. He suggested that a useful future agenda item for the Committee would be an update on data analytics across UC Health. Many of the questions arising in the discussion involved data requests that are time-consuming to address. Dr. Stobo concurred and stated that this item would be on a future agenda.

Regent Makarechian asked why UC’s net patient revenue per bed was so much lower than Kaiser’s; this was an important point for the public to understand. Dr. Stobo explained that one industry benchmark is net patient revenue per adjusted patient day or per adjusted patient bed. Even when data are adjusted for various factors, such as taking care of sicker patients and high labor costs in a geographic region, UC’s number of full-time equivalents and total labor costs are higher than the benchmark.

5. **DISCUSSION OF MISSION BAY NEUROSCIENCES RESEARCH BUILDING (BLOCK 23A), 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.]

Chancellor Hawgood explained that this item for the proposed UCSF Mission Bay Neurosciences Research Building (Block 23A) would be brought to the Regents for preliminary plans funding at their March meeting, at which time more information on financial plans for the building would be available. This project represented a significant investment by UCSF in its expanding neurosciences research program. The new building would provide a primary home for a new neuroscience institute and for clinical dry and wet research in the Departments of Neurology, Neurological Surgery, Psychiatry, and UCSF’s basic neuroscience graduate program.

At the July 2015 meeting, Chancellor Hawgood had discussed the campus’ capital strategy, which was motivated by necessary seismic work at the Parnassus and San Francisco General Hospital campuses and the sale of the Laurel Heights campus, among other factors. This was an opportunity for UCSF to consolidate its capital plan on a smaller number of sites within San Francisco and to bring together similar programs. Chancellor Hawgood recalled current UCSF capital projects in the preliminary planning or initial stages: the East Campus Phase 1 (Block 33) Building, the Precision Cancer Medicine Building, and a building at 2130 Third Street that would become the new home for the Department of Psychiatry, which would relocate from the Parnassus campus.

UCSF’s vision for the neurosciences at Mission Bay encompassed the full spectrum of basic, clinical, and translational research. UCSF already had one of the largest

neurosciences complexes in the world in Rock Hall and the Sandler Neurosciences Center. Research into the mechanisms of the brain and nervous system, as well as neurologic and neurodegenerative diseases, was generating exciting new discoveries which UCSF faculty were translating into new treatments and therapies. UCSF needed additional space for neuroscience research to further develop and integrate its programs in mental health and psychiatry into its overall vision for the neurosciences. There is general recognition that a revolution in mental health research is under way. Much of the basic biologic neuroscience was beginning to translate into advances in mental health. UCSF was positioned to be in the forefront of research into the biologic and genetic components of psychiatric disorders and to translate that research into the understanding and treatment of developmental psychiatric disorders, mood disorders, schizophrenia, and other disorders.

Neurology and neuroscience basic research are also experiencing growth. UCSF was working to ensure that collaborations would be embedded across the entire field of neuroscience at UCSF. Donors were recognizing this opportunity. In just the past six months, UCSF programs had attracted significant philanthropic support, including a \$177 million program gift for the Memory and Aging Center as well as a \$20 million gift for the formation of a new Kavli Institute for Fundamental Neuroscience. The UCSF Memory and Aging Center focuses on brain diseases associated with aging, and was launching research on the specific aspects of depression in the elderly. Research in the new Kavli Institute would focus on brain plasticity or changeability. Collaborations would allow investigators to better understand how aberrant brain circuits are at the root of depression and bipolar disorders. Both of these expanded programs would move into the new building.

The proposed new building would provide a primary home for the new neuroscience institute. It would bring UCSF neuroscience together with a translational focus and maximize collaborative opportunities among neurology, psychiatry, neurosurgery, the Institute for Neurodegenerative Diseases, and basic neurosciences. The building would be located on Block 23A, currently a surface parking lot. It would complete the central quadrangle of the Mission Bay campus, filling the fourth side. The building would be complex. The first floor would be occupied by clinics and patient care areas in neurology and potentially neurosurgery; the second floor would be devoted predominantly to dry laboratory research and would be the new home for a greatly expanded Memory and Aging Center; the upper floors would provide traditional wet laboratory facilities, mostly for the Department of Psychiatry; and the top floor would house the vivarium, allowing UCSF to move an old facility currently located on four acres of land at Hunters Point. The vivarium would be used by Professor Stanley Prusiner in his work on prion diseases. UCSF was projecting a six-story, 270,000-gross-square-foot building.

The campus would present a proposal for preliminary plans funding at the March Regents meeting. UCSF was currently projecting a \$336 million budget to be funded by gifts and debt. The campus had a gift target of \$50 million. The \$286 million of debt for the building would be campus debt, not health system debt. Chancellor Hawgood noted that the campus had received a signed pledge for a bequest of \$125 million to offset the

\$286 million of debt. The donor would pay the interest on the borrowing of that \$125 million until the bequest became available. UCSF had also secured a signed pledge for \$15 million for capital against the \$50 million gift target. Allowing for the subtlety of the bequest arrangement, UCSF had actually achieved \$175 million in philanthropy for the capital costs of the building. The lead donor was also providing \$50 million in spendable money for programs to allow UCSF to recruit new investigators. Chancellor Hawgood stated that he would provide more details at the March meeting on additional indirect cost recovery and clinical income that this building was expected to generate for the campus and health system. The building was integrated into the campus' ten-year capital plan. The campus would meet all debt service ratios throughout the next decade with this building in addition to other capital projects recently approved by the Regents.

Regent Reiss praised the project and the leading role UCSF was taking in this area of research. She asked how UC Health's new perspective on systemwide expenses and revenue would affect a project like this one. She asked if the University would try to project the future operating revenue and expenses associated with the building and if UC Health's systemwide focus would affect the project. Chancellor Hawgood responded that UCSF has a formal budget and financial projection model that looks ten years into the future. A projection is carried out for the full UCSF campus as well as separate analyses for the UCSF health system and the UCSF academic campus. On this project, capital and operating expenses and any income, except for the small amount of clinical income, would reside with the academic campus. Chancellor Hawgood emphasized that UCSF considered its projects from both the health system and academic campus perspectives. The campus' financial projection is updated every year. Currently it showed positive margins for the next decade, with this building's capital and operating expenses taken into account. UCSF was proud of its robust financial planning.

In response to a question by Regent Reiss, Chancellor Hawgood confirmed that for a building like this one, the predominant source of revenue would be research funding from the National Institutes of Health (NIH). This funding would provide overhead expenses and could offset operating costs.

Regent Sherman asked that at the March presentation the campus demonstrate how this project would affect its overall financial standing, on an incremental basis. Chancellor Hawgood stated that this information would be presented. In its planning for a new building, UCSF develops detailed pro forma documents, including expected new revenue and expenses from all sources.

Regent Sherman observed that this building would take the place of a parking lot but that no new parking would be constructed. Chancellor Hawgood responded that UCSF had a number of other surface parking lots that would eventually be sites for future buildings. There was currently other parking available and UCSF did not need to build a parking structure.

In response to another question by Regent Sherman, Chancellor Hawgood confirmed that the new building was integrated into an overall traffic plan for the Mission Bay area.

UCSF had an updated traffic and transportation plan that included the impact of this building.

Executive Vice President Stobo responded to Regent Reiss' earlier question about how a consolidated systemwide approach might affect projects like this one. One reason for Committee on Health Services review of capital projects was to ensure that buildings are evaluated with a systemwide perspective. This made sense in a challenging financial environment where philanthropy was becoming a larger part of UC revenue. Rating agencies evaluate UC Health as a system. The financial performance of one medical center affects the cost of borrowing for the others. It was important to examine how capital was being used and how the system was performing overall. Chancellor Hawgood reiterated that the debt for this project would not reside in the combined UC Health pool, not in UCSF Health, but would be borne by the UCSF academic campus. He acknowledged that UCSF needed to ensure that this project would not have any negative effect on the general obligation debt of the UC system.

Regent Sherman asked if it ever occurred that one medical center competes with another for NIH or other grant funding. Committee Chair Lansing and Chancellor Hawgood responded in the affirmative. Chancellor Hawgood explained that every UC campus competes for NIH funds with every other university science program in the U.S. Although individual funded projects still accounted for a large part of NIH funding, there was currently a trend in science and in NIH funding toward larger, multi-team projects, many of which involve more than one campus. UCSF carries out many such efforts with UC Berkeley, bringing a team together and applying for NIH funding as a team. Dr. Stobo also acknowledged the competition for NIH funding, but stressed that there was increasing collaboration at UC Health, in precision and personalized medicine, breast cancer diagnosis, prevention, and treatment, and study of degenerative brain disease. Several premier UC research programs were the result of multi-campus collaborations.

Regent Makarechian suggested that the University might save money by not disclosing its budgets for building projects. Contractors who already know a project budget will not make bids that are favorable to the University. When developing a building project, UC does not know what the full cost will be. He suggested that a campus first seek approval from the Regents for a design budget, then obtain cost estimates from a number of contractors, and then present a project budget to the Regents. Chancellor Hawgood responded that such an approach would make sense. Historically, UCSF had been asked to provide budget projections. This information could be presented in a closed session meeting or not at all, until the campus seeks full budget approval.

Regent Makarechian emphasized that UC might save millions of dollars in this manner. He asked what would happen to vacancies when facilities are moved to the new building. Chancellor Hawgood responded that some neuroscience researchers would move out of existing buildings. There would be a substantial number of new recruits to fill the new building. The vacated spaces in existing buildings would be filled with scientists and researchers in other disciplines, such as cancer research. UCSF had a great deal of demand for additional space.

**6. REPORTS FROM THE UNIVERSITY OF CALIFORNIA MEDICAL CENTERS**

[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.]

UCSF Health Chief Executive Officer (CEO) Mark Laret began the discussion by highlighting the system and local aspects of UC Health. There were significant unexploited opportunities for sharing among the medical centers now being explored under the leadership of Executive Vice President Stobo. At the same time, each medical center operated in a very different environment, with a unique history and a unique role in its region. He referred to earlier discussion about consolidation of training programs and advised that such consolidation would be complex, given accreditation requirements.

UCSF had just marked the first anniversary of its new hospital at Mission Bay, a \$1.5 billion project completed on time and under budget. The project had added \$115 million in annual depreciation and interest expense and ongoing operating expenses of \$30 million to \$40 million. The campus had anticipated this financial deterioration for the current and next year; it was part of the challenge of building a new hospital.

Much of UCSF's current growth was growth in Medi-Cal patients, for whom UCSF is paid about 50 cents per dollar of cost. UCSF was trying to offset this cost with payment it receives for commercially insured patients, about \$1.50 per dollar of cost. UCSF was focusing on cost reduction and process improvements. In November 2014 the Regents had approved an affiliation between UCSF and John Muir Health, a private, not-for-profit community hospital system in the San Francisco Bay Area. The goal of the affiliation was to develop a healthcare delivery system in the Bay Area somewhat like Kaiser Permanente, and it was almost ready to receive its insurance license. The affiliation would take on the financial risk of population health and the responsibility for community well-being and would earn financial returns by keeping patients healthy and out of the hospital and by having its patients go to the most efficient provider available. In the near future, UCSF and John Muir Health would seek to lease space for a new outpatient care delivery center, most likely in Berkeley or Oakland.

UCLA Vice Chancellor John Mazziotta observed that the question of Medi-Cal patients and the payer mix was essential for all the medical centers. UCLA Health enjoyed good ratings and was doing well financially, but the warnings in the financial forecast discussed earlier by Dr. Stobo were apparent at the local level for UCLA. On the subject of patient capacity and access, Dr. Mazziotta reported that all four UCLA hospitals remain full most days of the week. Forty to 60 patients per week do not have beds. UCLA's emergency department diverts ambulances to other facilities more than 50 percent of the time. This situation affects patient satisfaction and could affect patient safety. An increasing number of unscreened patients changes the payer mix and affects the training of residents in the emergency department. UCLA was considering adding patient beds to the Medical Center in Westwood. Partnering with community hospitals had proven difficult. In collaboration with Cedars-Sinai and Select Medical, UCLA would soon open a rehabilitation hospital with 138 beds in Century City. UCLA was



seeking to develop partnerships with long-term acute care hospitals and skilled nursing facilities.

In its academic mission at the School of Medicine, UCLA Health faced challenges in recruiting and retaining qualified faculty, not always being able to offer competitive compensation. UCLA was pursuing philanthropy and development of intellectual property as new revenue sources.

UCLA Health was growing through mergers and acquisitions with physician groups. Often these are primary care doctors, and the cost of their practice is high. This cost would be subsidized by UCLA until further agreements with community hospitals for profit and risk sharing provide relief. These large subsidies for primary care were exacerbated by the high cost of installing electronic medical records systems. In some cases, UCLA's plans to take on an outside practice group in a merger do not come to fruition due to UC labor costs and UC's payroll structure. Dr. Mazziotta observed that there were opportunities for UCLA to move into outpatient surgery and imaging centers to offset losses and the cost of subsidies, as well as opportunities to develop joint strategies to reduce the cost of deployment of electronic medical records at new sites.

While medical schools are structured around departments, Dr. Mazziotta stated that this structure does not correspond to how medical centers in fact operate in research, education, and patient care. Greater integration was a desirable goal and UC's non-academic competitors were pursuing this direction, but there was less incentive to change at UC and to move toward greater integration. UC's patients and customers would demand to be the center of attention, as they should be. In order to save money and be competitive, UC medical centers must develop a less hierarchical structure and a funds flow model that brings practitioners and departments into a cooperative, integrative mode, rather than isolation. This could only be accomplished if the model has rewards for faculty and makes practical sense. There was much redundancy in units with separate administrative structures. With the right integration, this could be reduced.

UC Irvine Vice Chancellor Howard Federoff reported that UCI Health had begun a comprehensive strategic planning effort that would include education, research, and clinical care, with the principal goal of identifying synergies and possible collaborations across historical boundaries. The planning would be completed by the end of the current fiscal year and would have implications for how UCI deploys resources. Like the other medical centers, UCI must consider its current position and what its position should be in its region and relative to competitors. UCI must be able to attract a greater fraction of commercial payer patients and penetrate the market in areas where it had not been successful in the past, such as the Newport coastal area. Growth strategies and decisions were influenced by the not insignificant start-up costs associated with acquisition of additional ambulatory care capacities. Dr. Federoff described challenges for UCI Health's inpatient care. UCI's emergency department diverts patients every week. In the last quarter, UCI was in diversion mode more often than all other hospitals in Orange County. This has a profound impact on transfer patients UCI can take. UCI was examining the possibility of increasing its inpatient capacity, but its physical plant is relatively modest

in size. At the most, UCI could create about 45 to 50 additional beds at a high cost per bed. As an alternative, UCI was considering partnering with a high-quality community hospital that would allow it to move some of its inpatient business, deliver high-value clinical care in that community hospital, and balance the distribution of patients who are referred for tertiary and quaternary care to the UCI Medical Center. Another challenge for UCI Health is to develop collaborations across the Southern California region, and UCI was in the process of working with Corona Regional Medical Center.

Dr. Federoff discussed his concern about adequate investment in medical education and UCI's goal to create a model of inter-professional education and practice. UCI was anticipating the creation of three new schools in the health sciences for nursing, pharmacy, and population health over the next five years or more. The planning was based on this inter-professional model and consideration of the changing nature of health care.

UCI Health was currently a small health system, with a seven percent share of its primary service area. Its plan for growth needed to be strategic, and it would grow through partnerships. These potential partnerships were being discussed. Some would mature, while others would likely not be pursued. Dr. Federoff concluded that this was a strategy for the future that would allow UCI Health to become a greater factor in healthcare delivery for the county and region.

UC San Diego Health CEO Patricia Maysent recalled that the UCSD Medical School was founded in 1968. It was now ranked 17th in the country and its research faculty ranked third in the amount of National Institutes of Health funding per faculty member. UCSD has unique opportunities due to its market. It has close relationships with the biotechnology industry. Of the three missions, education, research, and clinical care, the clinical mission was the least mature at UCSD. UCSD had made efforts to address this, and its high rankings among hospitals reflected these efforts. UCSD has a combined capacity of 563 beds. It has long-standing strategic relationships with the Veterans Administration and with Rady Children's Hospital. UCSD operates in one of the most sophisticated and consolidated markets in the country, competing with Sharp, Scripps Health, and Kaiser.

When Ms. Maysent joined UCSD in 2012, UCSD Health chose to focus on two important areas – cost structure issues and a renewed strategic plan to address pressures in the market. Despite competition, UCSD's market share has continued to grow, with significant growth over the past five years. UCSD's hospitals were at capacity and were currently turning away about 80 transfer patients per month. The opening of the Jacobs Medical Center in the fall would allow UCSD to absorb that excess capacity. UCSD would open the Altman Clinical and Translational Research Institute in March, the Jacobs Medical Center in October, and an outpatient pavilion in late 2017. UCSD was engaged in strategic planning efforts for the Hillcrest campus, a former county hospital built in the 1960s with seismic, structural, and infrastructure problems. UCSD had been acquiring parcels of land so that it would ultimately own a contiguous block of real estate at the Hillcrest site; this would allow for major developments.

Over the previous three years, UCSD Health teams focused on cost reduction, capacity optimization, and revenue cycle, which resulted in improved cash flow of about \$250 million. The number of days' cash on hand grew from 22 in 2012 to 119 at present. 2015 was a positive year financially, with operating income of about \$194 million. There were some positive end-of-year adjustments from Medi-Cal which UCSD was not expecting again in the current year.

In spite of this good news, UCSD Health was facing major challenges. The payer mix was in flux, and UCSD's goal for operating income in the current year was lower, at \$148 million. UCSD Health's support for School of Medicine faculty was substantial but at an unsustainable level. UCSD was moving toward a new production-based compensation model for faculty that would reward clinical production. This was expected to expedite patients' access to UCSD Health faculty. UCSD was also redesigning its ambulatory care processes to remove barriers and obstacles for patients.

In connection with the opening of Jacobs Medical Center in the fall, UCSD would be adding \$100 million in new expenses. UCSD Health finances would experience a significant dip and it would take years for revenues to catch up with expenses. During this time, UCSD Health would not reduce its support for the School of Medicine. Ms. Maysent observed that this was a difficult situation, but that all the involved parties, the UCSD campus, the School of Medicine, and the Medical Center, had an interest in working through it.

Over the last several years, UCSD has established an affiliation with El Centro Regional Medical Center and taken over management of that hospital. The Imperial Valley region has a population base of about 170,000 with serious medical needs and serious gaps in clinical infrastructure. This was an opportunity for UCSD Health students and faculty. In the Coachella Valley, UCSD was working with the Eisenhower Medical Center to develop its cancer center. UCSD was working with the Universal Health Services system for three other hospital affiliations in Riverside County. In north San Diego County, UCSD had set up an affiliation with Tri-City Medical Center.

Ms. Maysent reported that UCSD Health has been developing a clinical integration network with community physicians. In this approach, UCSD does not purchase practices, take on risk for salaries, or pursue financial integration. Instead, it creates a vehicle for contracting and population health management. The challenges in this approach are obstacles like independent practice association relationships, information technology demands, and integration of clinical records. An information technology investment in the range of \$20 million to \$40 million would probably be needed. Under this arrangement, community physicians can remain independent.

UC Davis Medical Center CEO Ann Madden Rice reported that UCD was continuing to see improvements in patient satisfaction and had carried out a successful revenue cycle conversion. The number of days' cash on hand had risen to 90. UCD had a stable workforce that was recognized for its diversity. There would be some turnover in senior positions, which represented a time of opportunity. The UC Davis Health System had

enjoyed successes but faced significant challenges, and its margins were the lowest in the UC Health system. The volume of Medi-Cal patients had increased significantly. Medi-Cal visits to the Davis emergency department increased by 68 percent over the previous two years, compared to an overall increase in volume in the emergency department of 26 percent. Medi-Cal patient days increased by 20 percent over that period. More than one-third of UCD patients are sponsored by the Medi-Cal program. The UCD Health System is proud of its commitment to this population, but State underfunding for Medi-Cal patients was putting the Davis clinical enterprise at risk. UCD Health was maintaining its funding for the School of Medicine at the same level despite these difficulties and was trying to address capacity challenges. The UCD emergency department has seen a large increase in mental health patients and has partnered with a local mental health hospital to move some of these patients. The Sacramento area market is highly consolidated. UCD Health's three main competitors are well funded and aggressive. Currently there were only three non-government, non-district hospitals left in Davis' market, and UCD was working with them more than ever before. UCD has an opportunity to expand its cancer care network. UCD has carried out a great deal of staff training to reduce costs while remaining very mindful of the need to maintain quality. UCD was engaged in cautious planning on inpatient capacity. In the short term, UCD Health would need more patient beds, but this might not be a need for the long term. Ms. Rice anticipated pressure from payers to move more types of care, such as single joint replacements, to an outpatient basis. UCD Health had 619 patient beds and was very full. It was leasing space for ambulatory services. UCD Health competed in a difficult market and was probably the first of the five UC medical centers to experience quite this kind of inundation of Medi-Cal patients. She anticipated that the other UC medical centers would experience this over the next year or two.

Regent Reiss stressed that patient capacity was an issue of concern for every medical center, and that it seemed to be related to the expansion of the Medi-Cal program. Given the difference in reimbursement for Medi-Cal versus commercial payer patients, she asked if it was legal, in the case of non-emergency patients, to take commercial patients in preference to Medi-Cal patients. She asked if UC could find a way to treat Medi-Cal patients at lower cost.

Committee Chair Lansing emphasized that one of UC Health's missions is to serve the underserved.

Mr. Laret explained that Medi-Cal growth was one reason why UCSF had many patients; another reason was that UCSF had worked to target areas of specialization, or "destination programs," such as organ transplant, brain tumor, and cancer services. In these fields, UCSF wanted to be the hospital of choice for referring physicians in other systems. UCSF does not discriminate based on payer. UC has a goal of offering its fair share or more of service to the community, but Mr. Laret cautioned that there was a limit to what UC can do. UC Health would bankrupt itself if it accepted all patients. The challenge was to ensure that other providers like Kaiser, Sutter, Sharp, and Scripps do their share.

Committee Chair Lansing underscored UC Health's mission to serve the underserved. UC Health was facing financial problems which could be settled in different ways. UC Health would continue to fulfill its duties and responsibilities in this area. UC Health does not discriminate among its patients.

Dr. Mazziotta noted that UC Health faculty can be found working in Veterans Administration hospitals, county hospitals, and free clinics. He stated his view that UC Health contributes much more than its share to public health. He referred to a recent meeting of Los Angeles area healthcare organizations that focused on underserved populations, and particularly on mental health care. The consensus of these healthcare managers was that collectively they might be able to have a demonstrable impact by engaging elected officials and government agencies. UC could help further this strategy. If UC manages its finances wisely it could be an inducement for other organizations to provide care in geographic areas and among populations that today received little or no care.

Ms. Maysent noted that the entirety of UC Health's market share was growing, not only the share of Medi-Cal patients. This accounted for the capacity challenges at UC medical centers. She observed that UC competes against Kaiser but offers Kaiser coverage to its own employees. A strategic lever that UC had not yet exploited would be to take care of more of its own employees.

Mr. Laret referred to Committee Chair Lansing's earlier comments about the UC Health mission. The question of its mission was a challenge for UC Health. County hospitals have a responsibility to care for the indigent. The UC medical centers' mission is teaching and research, and, along with that, to do their fair share or more of indigent care. This is a difficult balance for the UC medical centers to achieve, optimally supporting the academic mission and supporting the community. The current situation with Medi-Cal patients presented a risk to this balance.

Committee Chair Lansing commented on the extraordinary problem of crowded emergency departments, for UC and other hospitals. It is not easy to build greater capacity. Ms. Rice responded that UC needs to work with local and State government to address the emergency department capacity problem. In Sacramento County in the first week of January, the emergency room capacity was 298 beds for the entire county, but there were 550 patients.

Regent Sherman observed that UC Health was likely the largest or one of the largest providers of health care to Medi-Cal patients in California. He asked about UC's ability to negotiate better rates. Dr. Stobo responded that UC Health was not the largest but certainly among the largest of these providers. UC did not have the ability to negotiate these rates. He described an alternative payment methodology under which the provider accepts a certain risk for providing medical care, for a fixed payment amount. Some providers have used this approach successfully, and Dr. Stobo suggested that UC should study these cases. This would not be the only solution. There was a general feeling in the Medi-Cal administration in Sacramento that UC was not doing its fair share.

Regent Sherman asked if this perception was based on patient volume. Dr. Stobo responded that the Medi-Cal administration feels that UC charges are too high and that UC does not provide enough Medi-Cal outpatient care. UC Health was trying and would continue trying to educate Medi-Cal on this issue. Data indicate that UC is providing its fair share of care to Medi-Cal patients. This was a State policy issue and UC should be involved in the policy discussion. California was the fourth lowest state in the nation in terms of reimbursement rates. The first three years of Medi-Cal expansion were covered by federal funds but this cost would then gradually be transferred to the State. Patient volume would increase but funding would decrease, and reimbursement to providers would decrease. UC needed to be involved in this policy discussion to call attention to the fact that other providers were not providing their fair share of Medi-Cal care, and UC needed to deliver Medi-Cal services more effectively.

Regent Makarechian remarked that Kaiser was not taking Medi-Cal patients and was the most profitable of the health systems. At the same time, UC appeared to be subsidizing Kaiser by taking Medi-Cal patients. Kaiser cannot provide certain services and sends those cases to UC. He asked if UC could charge Kaiser more for the services Kaiser cannot provide. Mr. Laret explained that Kaiser does take on Medi-Cal patients, although a variable volume. Kaiser was involved with the healthcare exchanges. In northern California, Kaiser has been generous in supporting safety net providers with cash contributions. He acknowledged that UC did find itself in an odd situation by subsidizing Kaiser. UC was essentially taxing all its other health plans in order to make up for the Medi-Cal shortfall.

Committee Chair Lansing asked why Kaiser had the right not to take Medi-Cal patients. Mr. Laret responded that many not-for-profit hospitals offer very little care to Medi-Cal patients but feel that they are doing community service in other ways. Kaiser takes Medi-Cal patients in its emergency department, but its model is focused on the employed and on Medicare.

Regent Makarechian reiterated his question about why UC could not charge more for services it provides Kaiser. Mr. Laret responded that UC does charge Kaiser appropriately for these services. UCSF competes with Stanford and others in negotiating contracts with Kaiser.

Regent Reiss suggested that UC Health conduct a survey of all healthcare providers that take Medi-Cal patients. It was likely that few if any of these providers were able to provide that care within the Medi-Cal reimbursement rate. UC could join forces with these other providers to bring this issue before the Governor and State legislative leaders, to prevent the State from decreasing Medi-Cal reimbursement or perhaps to induce the State to increase it. She stated that there must also be a federal minimum requirement for the Medi-Cal reimbursement rate. Dr. Stobo responded that UC had arranged meetings with two of the largest Medi-Cal health plans in California, who are very much interested in these discussions and cooperation. The federal government was displeased with the State of California because of the low level of Medi-Cal reimbursement. The University needs to contribute to the discussion of these policy issues and partner with other

providers who are successfully providing services to Medi-Cal patients, and learn from those providers about how to best provide these services.

Committee Chair Lansing remarked that the medical centers were led by an outstanding CEO and senior executive team. She expressed confidence that UC Health would find solutions to the many challenges it was facing.

The meeting adjourned at 2:45 p.m.

Attest:

Secretary and Chief of Staff