

The Regents of the University of California

**HEALTH SERVICES COMMITTEE**

June 21, 2017

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

Members present: Regents Lansing, Makarechian, Reiss, and Sherman; Ex officio member Napolitano; Executive Vice President Stobo; Chancellor Hawgood; Advisory members Dimsdale, Lipstein, Ramsey, and Smith

In attendance: Regents Kieffer and Park, Faculty Representative White, Secretary and Chief of Staff Shaw, Deputy General Counsel Nosowsky, and Recording Secretary Johns

The meeting convened at 12:05 p.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 person addressed the Committee concerning the item noted.

Mr. Jim Rockoff expressed concern about ineffective remedies sometimes referred to as “integrative medicine,” such as homeopathic medicine, “cranial sacral therapy,” and “energy medicine.” These useless treatments harm patients financially and may cause them to delay decisions about unpleasant real medical options. Mr. Rockoff stated that some of these useless practices were being performed at UC medical centers and taught to some medical students. He asked the University to investigate this matter and where appropriate, to defund and prohibit these practices.

**2. APPROVAL OF MINUTES OF PREVIOUS MEETING**

Upon motion duly made and seconded, the minutes of the meeting of April 13, 2017 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 reported briefly on discussions that took place at a May retreat meeting of UC Health with the deans of the Schools of Medicine and the Medical Center chief executive officers, and chancellors. There were presentations on “big data” – the 16 million unique patient records held by UC. There are questions about ownership of

the data and how these data should appropriately be accessed. A working group was developing recommendations in this area. There was discussion about population health, and the advantages of working as a system in collecting financial and clinical data that may help improve care for large populations of patients. UC Health's cost reduction activities were also discussed. This systemwide effort has been effective. UC Health had established an annual goal of \$200 million in cost reductions; in the first three years of this effort, almost \$1 billion in reductions has been achieved. There was discussion of how these activities might be expanded to enhance revenue, to have a positive impact on health policy, and to reduce costs.

Dr. Stobo presented a financial summary chart for UC Health for fiscal year 2017 with the year-to-date results for March and briefly reviewed the figures for modified operating income before Health Systems support, modified earnings before interest and depreciation, days' cash on hand, and debt service coverage.

Regent Sherman asked about the reasons for significant shifts at UC Davis and UC San Diego. Dr. Stobo responded that the figures for UC San Diego reflected the recent opening of a facility. UC Davis Health Chief Executive Officer Ann Madden Rice explained that the increases for UC Davis were due to a large increase in volume without an increase in costs, as well as \$50 million in prior-period adjustments to net revenue. In response to another question by Regent Sherman, Ms. Rice explained that when a hospital reaches a certain level of occupancy, there is an increase only in variable costs, not in fixed costs.

Dr. Stobo emphasized the tremendous uncertainty in the current health insurance marketplace and the rapidity of financial shifts in this marketplace. Fifty-five percent of UC Health expenses are labor-related. The University was about to enter negotiations with two large unions representing health services personnel at UC, the California Nurses Association and the American Federation of State, County and Municipal Employees. Labor costs were an essential factor in maintaining the stability of UC Health.

Dr. Stobo noted that some large health insurers are choosing to leave the healthcare exchanges in states where such exchanges operate. In California, UC is the provider for products offered in the exchange by large insurers. If one of these large insurers decided to exit the California marketplace due to the uncertainty of federal subsidies for individuals who purchase health insurance through an exchange, this would have an enormous impact on the University, amounting to hundreds of millions of dollars. Changes in the marketplace might occur rapidly without time for the University to make mid-course corrections or adjustments.

Advisory member Lipstein asked about UC Health's assumptions for its fiscal year 2018 budget. Dr. Stobo responded that UC Health was anticipating major changes in Medicaid, although these changes would likely be phased in over several years. He noted that Anthem had decided to exit health insurance exchanges in several states. If Anthem exited the California exchange, this would have a \$435 million impact on UC Health. Some individuals with Anthem coverage might migrate to other insurers with UC

products, but some might move to Kaiser, resulting in loss of revenue to UC. In order to respond to this situation, UC Health is making its best effort to reduce costs.

Committee Chair Lansing expressed concern about the dire effect that reductions in Medicaid would have on UC Health, even if the reductions were phased in over a number of years. Dr. Stobo expressed agreement, noting that the financial impact of major Medicaid reductions in California might amount to \$15 billion, while UC Health might experience a loss of \$2 billion to \$3 billion.

#### 4. **UPDATE ON THE AFFORDABLE CARE ACT REPEAL AND REPLACE EFFORTS**

[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.]

Chief Strategy Officer Elizabeth Engel presented an update on actions taken by the federal government related to proposed changes to the Affordable Care Act (ACA). The U.S. Senate was focused on Medicaid. One issue concerned the terms on which the federal government would decrease funding for the Medicaid expansion population. Under the proposed bill as currently reported, the expansion would be phased out in three years beginning in 2020 or 2021. Debate was ongoing about timing, but there appeared to be no question that this would occur. Another issue being discussed was the restructuring of Medicaid from an entitlement program to a per capita capped allotment. The California Department of Health Care Services estimated that under the House of Representatives bill to replace the ACA, in year one of the program, California would experience a \$700 million State budget deficit in order to maintain existing programs; as of year ten, there would be a \$5.3 billion State budget deficit. The State's options were limited – it could use its own funds, limit eligibility benefits, or limit payments to plans and providers. This would obviously have a significant impact on UC Health, as a provider of Medicaid care and a safety net institution.

In response to a question by Committee Chair Lansing, Ms. Engel confirmed that there would be a great increase in the number of uninsured patients. UC Health, along with other major hospital associations, was working to combat Medicaid cuts. In its bill, the Senate must achieve the same amount of savings as in the House bill, but conservatives in the Senate would not like to eliminate tax cuts that would achieve this.

Committee Chair Lansing asked what the replacement for Medicaid reductions would be. Ms. Engel responded that \$140 billion in funding would go to the states, to be directed toward a variety of problems, but this funding would not address all the proposed reductions. Executive Vice President Stobo underscored that the situation would become more difficult over a number of years as the program was phased in.

Committee Chair Lansing asked about coverage for patients with pre-existing conditions. Ms. Engel recalled that the House bill allows states to waive the ACA requirement that health insurance plans are prohibited from charging patients more for pre-existing

conditions. The Senate appeared to wish to preserve these ACA protections. It was unclear how this question would be resolved.

Regent Reiss reflected that the U.S. Congress was considering two issues, restructuring Medicaid and ending the federal reimbursement for the Medicaid expansion population. If and when this occurred, the focus would shift to the states and for UC, to decisions by the California Legislature. Ms. Engel observed that placing caps on federal payments did not take into account possible future situations such as unexpected costs or growth over time, public health emergencies, increasing costs due to an aging population, or high costs for necessary drugs. These caps represented a shifting of costs to the states.

Advisory member Lipstein noted that action being proposed to repeal the ACA would amount to an \$830 billion cut to Medicaid, replacing this with only \$150 billion.

Advisory member Smith raised the issue of how the rules of Medicaid would be worked out. He anticipated that this would be a state-by-state decision. Policy decisions concerning citizenship checks, work requirements, and co-payments might be left to the states.

Dr. Stobo noted that UC Health has been actively pursuing a Medicaid strategy to (1) maximize the reimbursement it receives through Medicaid, (2) establish contractual relationships with the largest Medicaid-managed care plans in the state, and (3) work toward more effective management of care of the Medicaid population to better align cost and revenue.

Regent Kieffer asked about the situation of other states with academic medical centers where insurers have exited the health insurance exchanges. Dr. Stobo responded that the Governor of New York had taken the position that if an insurer exits the exchange, this insurer may no longer sell insurance in the State of New York. Regent Kieffer asked if this had occurred in any other states or if there were other states where an impact was visible. Dr. Stobo responded in the negative. He noted that academic medical centers face different situations in states with or without Medicaid expansion. The University's baseline position is opposition to any reduction in Medicaid.

Regent Sherman asked about the impact of a single payer health plan in California. Dr. Stobo estimated that the financial impact of such a plan would amount to about \$400 million. While opinions of such a plan vary, it was important that California was not merely waiting for the federal government to act, but was seeking to take actions of its own to preserve its insurance exchange and Medicaid expansion.

Regent Sherman asked if it was more likely that UC's reimbursement rates would decrease under a single payer plan. Dr. Stobo responded in the affirmative. Ms. Engel added that California's exchange, Covered California, had announced a new policy to combat uncertainty about funding for subsidies. Covered California was directing health plans to attach any increase in rates to "silver level" plans subsidized by the federal

government, a way of generating more federal subsidies for those who would be subject to rate increases.

Dr. Stobo drew attention to the fact that another area of revenue, research support, was also under threat. He estimated annual National Institutes of Health research funding to the UC system at about \$2.1 billion. There was a proposal to cap indirect cost recovery at ten percent, which would represent an enormous loss for the University. UC Health did not believe that this proposal would succeed in the U.S. Congress and was working with its colleagues and partners to oppose such an action. Nevertheless, there were means for the U.S. presidential administration to implement a ten percent cap without Congressional action. Dr. Stobo described this as a disconcerting prospect.

President Napolitano related that the University's Chief Financial Officer had studied the potential impact of a ten percent indirect cost recovery cap and estimated this impact to be in the range of \$460 million or more. She underscored the point mentioned by Dr. Stobo that while the University might seek relief from Congress, there were other administrative ways that this cap could go into effect. The University was engaged in scenario planning with regard to federal action and the final form that this legislation would take. President Napolitano anticipated that this would be a block grant and per capita cap that would remove a tremendous amount of funding from Medicaid, as much as \$650 billion to \$750 billion. If this block grant structure were implemented by the federal government, UC would need to work with the State Legislature on how monies received from the federal government would be allocated among California healthcare providers. The State does not have an equivalent of the federal Centers for Medicare and Medicaid Services, and therefore UC must have a good strategy for the parameters of the funding it would receive from the State. The University must plan now and work at the federal and State levels, even though it might take a year after the legislation is finalized for the full impact of the legislation to be felt.

Dr. Stobo stated his view that the State should do what it can to make it as onerous as possible for major insurers to exit the California exchange. Regent Kieffer asked if legislative action would be desirable, and if the Governor or Legislature could take any actions to prevent insurers from exiting the exchange.

Dr. Smith observed that some insurance companies had exited insurance exchanges due to uncertainty about whether the federal government would honor the original agreements that established the exchanges. If the federal government decided not to honor these agreements, the University should consider carefully the consequences of asking the Governor to insist that insurance companies abide by the agreements in a situation where the insurance companies would clearly lose money. Dr. Stobo respectfully disagreed with this view. He stressed that not all insurance companies had been leaving the exchanges in other states, and not all were seeking to exit the California exchange. Two insurance companies had found a way to make this situation work financially, and a third company should be able to do the same. Ms. Engel added that Covered California's new policy might mitigate these concerns. The California exchange had asked insurers to submit two

sets of rates by the end of the current month; one set of rates assuming that subsidies are in place, and a higher set of rates assuming that subsidies are not in place.

Committee Chair Lansing asked that the Committee be kept up to date on developments. Regent Sherman requested a concise analysis on any U.S. Senate action on the ACA.

## 5. **UCSF HEALTH BUDGET OVERVIEW, SAN FRANCISCO CAMPUS**

[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.]

Chancellor Hawgood began the discussion by recalling that since 2014, UCSF's healthcare delivery mission had undergone a transformation. UCSF had transformed the alignment of the physician practices at the School of Medicine and the Medical Center into a single governance model. UCSF had opened a \$1.5 billion hospital, adding almost 400 beds and grown its revenue base at a compound annual growth rate of about ten percent. The campus' current-year budget was approximately \$4 billion. UCSF had engaged in a joint venture with John Muir Health to develop an Accountable Care Organization, Canopy Health. All these steps were planned strategically, taking into account financial implications. UCSF had outperformed its planned budget and was a year ahead of its financial projections.

UCSF Health Chief Executive Officer Mark Laret also underscored UCSF's positive financial performance, ahead of plan. He discussed a chart showing the current year budget versus the projected fiscal year end, at the end of the current month. UCSF had budgeted aggressive growth for its average daily census and exceeded that target. Revenue would be close to \$3.9 billion. UCSF's earnings before interest, depreciation and amortization (EBIDA), an important factor for cash-intensive businesses, would outperform the budget by about 60 percent. There had been an improvement in the number of days' cash on hand, and the debt service coverage ratio was better than expected.

Mr. Laret then presented a chart with figures for EBIDA and net income for fiscal years 2014 through 2018. He described fiscal year 2016 as a nadir, with EBIDA of \$85 million and a loss of \$136 million. This outcome was in fact better than expected, because UCSF had planned for a low point at the opening of the Mission Bay Hospital. UCSF believed that it was emerging from this low point; the campus was projecting EBIDA of \$301 million and net income of \$87 million for fiscal year 2018. In its budgeting for 2018, UCSF was maintaining its status quo assumptions. UCSF was not assuming cuts to the federal 340B Drug Pricing Program or cuts to Medicaid beyond any the campus was already aware of.

Regent Sherman asked about the magnitude of the non-cash portion of Other Post-Employment Benefits (OPEB), which was excluded from the figures presented. UCSF Chief Financial Officer Barrie Strickland responded that the projection for UCSF Health for the beginning of the fiscal year was approximately \$137 million. There had been

changes to that estimate, and Ms. Strickland anticipated that this cost might be substantially lower, or even a negative number for this fiscal year. Mr. Laret added that the calculation of health benefits uses historical health inflation numbers, about five, six, or seven percent. There was discussion at UC of a policy to cap this number at a lower level and bring this estimate within a more realistic range. Regent Sherman asked about the actual cash outlay for this year. Ms. Strickland responded that this was about \$28 million.

Regent Makarechian requested clarification of the proposed cap. President Napolitano responded that the Office of the President was contemplating a cap of three percent on OPEB.

Regent Sherman asked if this was an actual cap, not merely an accounting exercise, such that if costs rise above the cap they would become the responsibility of the retirees. President Napolitano responded that the cap would be an actual cap and might have this effect. Retirement benefit plan design could be modified to mitigate this effect.

Mr. Laret continued with the presentation, discussing a chart with figures for cash and days' cash on hand. The number of days' cash on hand had reached a low point in 2016 after the opening of the Mission Bay Hospital but was increasing again. He pointed out figures showing cash specifically for Benioff Children's Hospital Oakland; this hospital had strengthened UCSF's balance sheet.

Mr. Laret then outlined some major concerns for UCSF's planning. The Mission Bay Hospital had reached capacity within months, rather than years, as the campus had anticipated, and \$230 million in expenses had been added in depreciation, interest, and operating expenses. While much of this had been mitigated by increased patient volume, this remained a significant operating expense. Another major project, the replacement of Moffitt-Long Hospital, which needed to be accomplished by 2030 for reasons of seismic safety, was now within UCSF's planning horizon. The cost of this project would likely exceed \$2 billion.

Advisory member Lipstein asked how many patient beds were on the original UCSF campus, before Mission Bay was built. Mr. Laret responded that there were currently about 450 beds in the Moffitt-Long Hospital, while there were 289 beds at Mission Bay and potentially 200 in Oakland. He observed that in older facilities, the actual licensed number of beds may not be meaningful and the effective capacity is lower, since current medical practice favors private patient rooms rather than several beds to a room.

Mr. Laret turned to another topic of concern for UCSF, the financial performance of Benioff Children's Hospital Oakland. This affiliation was of strategic importance to UCSF, providing access to the East Bay. This hospital cares for patients with severe and complex conditions and who find themselves in very trying circumstances. Over 65 percent of these patients are covered by Medi-Cal and reimbursement for services is not entirely reliable, making planning difficult. UCSF was projecting a \$20 million loss for fiscal year 2017 and negative EBIDA. UCSF was undertaking a number of cost and

efficiency improvement initiatives and revenue enhancement activities in order to be able to continue to maintain important services for the Children's Hospital Oakland community in a financially sound manner. For fiscal year 2018, UCSF was projecting an income loss of \$16 million and EBIDA at zero.

Providing service to Medi-Cal patients is an important part of UC Health's mission, but Mr. Laret recalled that Medi-Cal reimbursement does not cover the cost of providing care. The percentage of this cost covered by Medi-Cal varies by UC medical center, ranging from 81 percent to 57 percent. In the past, compared to other UC medical centers, UCSF and UCLA cared for a smaller number of Medi-Cal patients. UCLA and UCSF have a different reimbursement mechanism than UC Davis, UC Irvine, and UC San Diego. All UC hospitals were losing money, but UCSF, due to growth in volume of Medi-Cal patients and its poorer reimbursement model, was facing a shortfall of almost \$300 million. Mr. Laret underscored that this was a reason for UCSF's position that the responsibility of caring for Medi-Cal patients should not be borne disproportionately by UC and county hospitals; other hospitals should share in this responsibility as well.

Regent Makarechian requested clarification of the differences in Medi-Cal reimbursement among the UC medical centers. Mr. Laret explained that the earlier 1115 Medicaid Waiver included a formula structured for UC Davis, UC Irvine, and UC San Diego as UC's historically "disproportionate share" hospitals to receive a higher payment percentages than UCLA and UCSF. In the past this was an appropriate mechanism and the University supported this formula, but as the Medi-Cal patient population has grown at UCSF, UCSF is paid less while it provides more service, leading to the loss of close to \$300 million. Another factor explaining the formula was the fact that there are no county hospitals in Irvine, Davis, and San Diego. In Los Angeles and San Francisco there are county hospitals and the responsibility for caring for Medi-Cal patients is shared by UC and the counties. Dr. Stobo confirmed that the University had agreed to this formula.

Regent Makarechian asked if this formula could be changed. Dr. Stobo responded that UC was now addressing this. Regent Sherman asked if the fact that UC Health works as a system was somehow detrimental in this situation. Dr. Stobo responded in the negative; it is only as a system that UC Health would be able to achieve improvements in Medi-Cal reimbursement.

Regent Kieffer asked how UC hospitals compare to other hospitals in terms of the number of Medi-Cal patients they care for. Mr. Laret responded that the situation might vary by each market but in general, UC medical centers are the largest Medi-Cal providers in their counties. In San Francisco, UCSF cares for more Medi-Cal patients than San Francisco General Hospital.

Regent Kieffer asked if this information is reported publicly. Dr. Stobo responded in the affirmative. Dignity Health is the other major provider of Medi-Cal inpatient services. UCLA Vice Chancellor John Mazziotta observed that there are outpatient clinics and

hospitals in Los Angeles owned and operated by the County, but where UC physicians and trainees deliver all the care. If these services are counted, UC is the largest provider.

Regent Kieffer and Committee Chair Lansing requested a figure for the overall percentage of Medi-Cal patients in the state who receive care at UC Health facilities. Regent Kieffer stressed that there was insufficient understanding in California at large about the important role played by UC Health in caring for Medi-Cal patients.

Regent Reiss referred to the Medicaid waiver formula mentioned earlier. She asked if the same medical procedure would be reimbursed at different rates at different hospitals. Ms. Strickland explained that Medi-Cal provides 1.75 times the fee for service to “disproportionate share” hospitals. If UCSF received \$100 for caring for a Medi-Cal patient, a “disproportionate share” hospital would receive \$175 for that care. Under the waiver reimbursement model, UC medical centers prepare a cost report and submit it to the State. The State reimburses the medical centers based on their cost structures. Through the year, before the medical centers submit this report, Medi-Cal pays on a per-patient-day basis, until the cost report is submitted. The Medi-Cal reimbursement is less than the cost of care. Mr. Laret emphasized that this was a reason for UCSF’s concern about the proposal for Medicaid block grants to the states. UCSF was already underpaid relative to its costs, and the block grant model would exacerbate this situation.

Mr. Laret then discussed another concern of UCSF, faculty practice accounting. Usually, bottom-line revenue reported is revenue for the medical center minus the expenses, including some physician-associated expenses. Medical centers around the country then typically make a fund balance transfer to their associated medical schools and faculty practices; these costs are not included in the bottom line but are still part of total payments. In its reporting, UCSF includes not only medical center revenue and expenses, but all physician revenue and expenses, yielding a smaller bottom line relative to other UC medical centers. Mr. Laret presented figures for UCSF that only accounted for physician expenses, as if UCSF were only a medical center, treating the faculty practice not as an expense but as a fund balance transfer. This accounting change would improve UCSF’s bottom line, EBIDA, days’ cash on hand, and debt service coverage. He stated that UCSF was not suggesting a change in UCSF’s current accounting approach, but that financial results for UCSF might be presented to the Committee in a form that allows for more accurate comparison with other medical centers.

Finally, Mr. Laret presented projected figures for UCSF’s 2017-18 budget. The campus was assuming an approximately 3.5 percent increase in inpatient activity. UCSF would need to find cost savings, efficiency improvements, and new revenue to achieve this budget.

Advisory member Dimsdale stated that this had been an interesting colloquy on controllable and uncontrollable costs. One potential controllable cost was related to faculty replacement, turnover, and loss. UCSF had been at the forefront of the UC system in examining faculty morale. He asked if UCSF had specific insights regarding faculty retention. UCSF School of Medicine Dean Talmadge King responded that for UCSF loss

of clinical faculty was currently a more urgent concern than the loss of academic faculty. UCSF clinical faculty have opportunities at other organizations which pay substantially higher salaries, in particular Kaiser Permanente. Even starting salaries might be as much as 20 percent higher, and this in the context of the high cost of living in the San Francisco Bay Area. UCSF has been striving to make improvements to the workplace environment so that faculty wish to stay, even at a lower salary. He acknowledged that this is a difficult problem to address.

Committee Chair Lansing remarked that the University is unique in the kind of research environment it can provide for faculty.

Dr. Dimsdale stated that UC could do more as a system to address this matter, by developing common measures of UC Health faculty turnover and loss and examining measures taken by each campus to retain faculty.

Dr. King observed that the single most difficult factor for UCSF was the cost of housing in the Bay Area; additional options for helping faculty move into homes would be desirable.

Chancellor Hawgood agreed with Dr. King's observation, but stressed that UCSF was not in a crisis. In general, the campus can recruit and retain faculty it wishes to recruit and retain. Faculty turnover rates in the School of Medicine were about six to seven percent, mostly among younger faculty who were not yet committed to a career at UCSF. Turnover rates were quite low among older faculty.

Mr. Lipstein asked how UC Health determines the appropriate amount of hospital earnings that a hospital can afford to provide in academic support, while continuing to renew its patient care infrastructure and sustaining its mission. Chancellor Hawgood responded that there were nuances in the situation of each medical center. The below-the-line transfer, when it is referred to as "academic support," gives the impression that it directly supports the research and education mission. In Chancellor Hawgood's view, the bulk of these funds are supporting investment in the health system: funds to recruit outstanding faculty and to provide resources to these faculty to start new programs. The below-the-line transfer allows other monies to be used for teaching and research; it is an investment not unlike investment in buildings and facilities.

Mr. Lipstein concurred that this was an important investment to make. He asked if these investments are surplus-financed or deficit-financed, and it seemed that at some campuses these investments are deficit-financed. Mr. Laret responded that this might be a fair characterization in some circumstances. The strength of the UCSF Medical Center is due to the strength of the School of Medicine. As State support for the School of Medicine has decreased, UCSF has replaced this with clinical revenue. Real pressure comes when UCSF is faced with the choice of making capital improvements or supporting the School of Medicine.

In response to Mr. Lipstein's question, Dr. Mazziotta observed that at certain moments there might be valid reasons for deficit spending, while at the same time bolstering the academic enterprise with intellectual property revenue and philanthropy.

UC Davis Health Chief Executive Officer Ann Madden Rice noted that a chart with financial figures for the five medical centers for one year only does not provide enough context to indicate how the medical centers are at different stages in their capital cycles. For example, UC Davis was furthest behind in seismic repairs, with about \$2 billion in expenditures to be expected over the coming ten years. Factors like this influence how a campus makes investments. It can be misleading to focus on only one point in time.

Advisory member Smith distinguished emergencies from ambulatory care-sensitive conditions. These latter conditions sometimes lead to hospitalization, but hospitalization can be avoided if there is effective outpatient care. He asked if there is a systemwide measure to determine the number of hospitalizations for ambulatory care-sensitive conditions. This might be a useful dashboard criterion, especially given the high cost of adding hospital beds.

Referring to the Medicaid fee-for-service rates, Dr. Smith stated his understanding that they represented a shrinking portion of UC's Medicaid reimbursement. He asked how much of this reimbursement was fee-for-service Medicaid, and how much was Medicaid-managed care, which does not have the negotiated rates of the Medicaid waiver, but has rates negotiated by the campuses and the health plans. Historically, many fee-for-service hospitalizations have involved Medi-Cal patients who had been excluded from managed care, but who would now be eligible for managed care. Mr. Laret responded that most of UCSF's Medi-Cal business, 80 percent or even as much as 90 percent, comes from managed care plans. In response to Dr. Smith's first question, he stated that UCSF does not examine the category of ambulatory care-sensitive conditions and acknowledged that this might be desirable, given UCSF Health's move toward a focus on population health. UCLA Health President Johnese Spisso added that UCLA was using its 160 clinic locations for secondary specialty care as well as primary care. Procedures like the first induction for bone marrow transplant therapy were being moved to outpatient settings.

6. **CLINICAL QUALITY DASHBOARD FOR UNIVERSITY OF CALIFORNIA MEDICAL CENTERS**

[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.]

UCSF Chief Medical Officer and Executive Vice President – Physician Services Joshua Adler presented the clinical quality dashboard with data for the quarter ending March 30, 2017. These data included figures for the medical centers, for UC Health as a whole, and for median performance of UC Health's national comparator group.

Dr. Adler briefly discussed the data for inpatient mortality. Hospital mortality across the U.S. had been declining over the last decade due to improvements in care, and at UC this

improvement was occurring at a faster rate. He then discussed 30-day readmissions, a criterion for which there are a number of factors that are not measured, such as socioeconomic status and geography. UC Health seeks to reduce all avoidable readmissions.

Committee Chair Lansing requested more detailed information regarding readmission rates, specifically, a breakdown of this category by causes of readmission: whether hospital infections or failure of care in the hospital, failure by the patient to follow instructions, or accident or some unexpected circumstance not related to the first hospitalization. She stressed that this is an important and widely examined criterion for hospitals, and it is important for UC Health to determine if it can improve outcomes in this area.

Dr. Adler outlined the known factors for readmission rates. Most readmissions occur between seven and 30 days from when a patient is discharged. Admissions within seven days are more likely to result from something that occurred during the hospital stay. For surgery patients readmitted within seven days, the foremost cause is infection. There is a host of categories of patients and causes of readmission in the seven to 30 day range. One significant cause is insufficient coordination of post-discharge care. In this area, UC hospitals have some responsibility and some opportunity to improve care, especially when patients are seen in UC outpatient clinics.

Advisory member Lipstein suggested that at a future meeting, one of the medical centers might make a presentation on actions it takes to prevent readmissions. This would be an opportunity to showcase the measures UC Health was taking to reduce surgical infections, to improve post-discharge coordination, and to enhance patients' adherence to medication instructions.

Regent Reiss noted that in penalizing hospitals, the Affordable Care Act does not distinguish among causes for patient readmissions.

Dr. Adler then continued his presentation of the data, with figures for central line-associated bloodstream infections. Committee Chair Lansing asked why UCLA Medical Center, Santa Monica appeared to be an exception, with a higher infection rate than all other UC hospitals, while UC Irvine had a low rate. Dr. Adler responded that the actual numbers of infections at the Santa Monica hospital were very low, but a single infection in a quarter can move a hospital's rate from 0.2 to five. Central line procedures at the Santa Monica hospital were being reviewed. UC Irvine Vice Chancellor Howard Federoff explained that an important factor is proper inspection of a central line to determine when it needs to be removed and replaced. It is important for nurses to know how to prepare a site in a manner that creates a surface unlikely to support infection. The UCI Medical Center's efforts had been able to sustain a very low rate of central line-associated infections. This approach is teachable and UC Irvine would share anything it has learned in this area.

Dr. Adler briefly outlined three further categories in the clinical quality dashboard, all pertaining to results of the Hospital Consumer Assessment of Healthcare, a survey of patient experience by the Centers for Medicare and Medicaid Services. This included patient feedback about how well physicians and nurses communicate. Finally, he presented charts showing a six-quarter trend for each location and each dashboard criterion.

7. **APPROVAL OF PROPOSAL ON WITHDRAWAL FROM CORPORATE MEMBERSHIP IN A HEALTH MAINTENANCE ORGANIZATION, DAVIS CAMPUS**

The President of the University recommended that the Health Services Committee:

- A. Approve UC Davis Medical Center's withdrawal from Western Health Advantage.
- B. Authorize the President, or her designee, after consultation with the Office of the General Counsel, to approve and execute any agreements reasonably required to implement the foregoing action, including any subsequent agreements, modifications, or amendments thereto, provided that such agreements, modifications, amendments, or related documents do not otherwise materially increase the obligations of the Regents or materially decrease the rights of the Regents.

[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.]

UC Davis Health Chief Executive Officer Ann Madden Rice introduced the item. She recalled that Western Health Advantage (WHA) had been formed in 1995. WHA had three owners, UC Davis Medical Center, Dignity Health, and NorthBay Healthcare. WHA was a not-for-profit, public benefit corporation. The partners had founded WHA in response to changes in healthcare market forces in the Sacramento and Northern California market, and the emphasis then shifted to full-risk capitation, an arrangement under which providers assume full financial risk for all of an individual's health care for a fixed dollar amount. When WHA was formed, UC Davis Health anticipated benefits from the corporation, including market share and increased opportunities for resident training. These objectives were not being achieved to the extent anticipated. The American healthcare system was now in a state of flux, with significant threats to plans and providers. Threats include cyber security exposure, impact of legislative changes, and changes in healthcare markets.

Ms. Rice stressed the view of UC Davis Health that the situation of a provider owning a health plan is not inherently a problem; however, remaining an owner in this health plan at this time in the Sacramento market was not prudent for UC Davis. UC Davis Health had attempted to work with its two partners to address business and strategic challenges, but had come to the conclusion that its views of prudent financial strategy and resolution

of business risks were different from those of the other board members. UC Davis had not been able to reconcile these differences. The campus had explored the idea of selling its interest in the corporation. Under California law, UC Davis Health may not transfer interest in the plan to a third party because it is a public benefit corporation. The other owners declined the opportunity to sell the plan in its entirety.

Ms. Rice noted that there was an outstanding loan to WHA that was created when the company moved from for-profit to not-for-profit status, and a payment was due to the Internal Revenue Service for that conversion. The loan stands, and UC Davis Health's withdrawal as owner would not change WHA's obligation to repay the loan. WHA would continue to offer health insurance in the greater Sacramento region.

Committee Chair Lansing asked about how this matter was being communicated to the public. Ms. Rice remarked that the fact that UC Davis would cease to be an owner of WHA would not change the ability of WHA to offer its product. UC Davis has held extensive discussions with its physicians about this change, and has discussed with WHA how to communicate to the greater Sacramento area that this is an amicable change in a business relationship. UC Davis and WHA would work jointly on public communications and news media inquiries.

Regent Kieffer asked about the differences between UC Davis' view of market risk and that of the other WHA owners. Ms. Rice responded that this case might provide lessons for future business relationships. Business partners need to be aligned in terms of the benefits they derive from an arrangement. In this case, WHA's pricing in the market had a different effect on UC Davis' business model as an academic medical center than on the WHA partners. When entering this kind of transaction, it is important to have an exit strategy; this might not have been considered when WHA was formed. Ms. Rice observed that the risk in the WHA business was not spread across UC Health but was limited to UC Davis. The UC Davis Health entity was not large enough to absorb this risk. In addition, UC Davis was the only one of the three partners that provided tertiary and quaternary care and so was incurring greater costs.

Regent Zettel asked if there was any risk of default on the outstanding loan. Ms. Rice responded that in UC Davis Health's view there was not a risk. This was an amicable parting of ways.

President Napolitano asked about the timeline for the withdrawal. Ms. Rice responded that UC Davis Health planned to notify WHA on June 23; withdrawal would occur 90 days later, according to the current bylaws.

Upon motion duly made and seconded, the Committee approved the President's recommendation.

**8. STUDENT HEALTH AND COUNSELING UPDATE**

[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.]

UC Health Medical Director of Student Health and Counseling Brad Buchman began the discussion by drawing attention to the magnitude of student health operations at UC, with about 265,000 students.

Student mental health has increasingly become an area of concern in overall student health. National trends indicate that mental health needs of U.S. students have grown in the last decades, and this has also been observed at UC. Revenue from increases in the Student Services Fee had enabled the hiring of additional mental health clinicians for UC's counseling centers. The University was nearing the end of year two of a five-year hiring initiative. Almost 80 percent of clinicians had been hired, while 20 percent of available positions were still under recruitment. UC was striving to reach certain diversity goals and respond to campus needs. During this two-year period, the University was able to measure student access to counseling centers. Most students who request an urgent appointment are seen the same day, and 97 percent of such requests fulfilled by the following day. For routine appointments, about 80 percent of patients are seen within two weeks. Dr. Buchman noted that student enrollment growth at UC had exceeded the assumptions made for the five-year initiative. UC Health was working to ensure that increased enrollment would also result in increased funding for UC student health centers.

President Napolitano asked about diversity in this hiring. Dr. Buchman responded that this varied by campus. Recruiting licensed individuals with the desired backgrounds at a salary level that UC can offer was not always straightforward. The campuses were committed to meeting diversity goals, but it would take some time to fill these positions. Executive Vice President Stobo stated that information and figures on diversity in these hires could be provided.

Regent Makarechian asked if the number of provider positions was proportionate to the number of students. Dr. Buchman responded in the affirmative; this was also the factor determining allocations of funds to the campuses. The International Association of Counseling Services recommends a ratio of one counselor to 1,000 to 1,500 students. Some campuses were within this range, others not. He noted that another generally accepted ratio for psychiatry services is one provider to 6,500 students.

Regent Makarechian asked if there were more student mental health issues and more suicides at some campuses than at others. Dr. Buchman stressed that any student suicide is a very sad event; the University examines these cases and seeks to understand the contributing factors. Some subpopulations of students are at higher risk, and UC is striving to meet their needs.

UCLA School of Medicine Dean Kelsey Martin emphasized the magnitude of student need for these services. UC medical school house staff also have needs for mental health services. Dr. Buchman responded that he was aware of medical student needs. House staff and residents are a high-risk population as well.

Dr. Buchman then reported on an audit of UC student health and counseling centers that had taken place in fall 2016, conducted by Keeling and Associates in conjunction with the Office of Ethics, Compliance and Audit Services. The audit found no significant gaps or deficits and documented solid performance. Areas covered by the audit included governance, credentialing, privileging, accreditation, quality issues such as peer review, quality improvement initiatives, clinical documentation, as well as workplace safety, vaccine management, professional boundaries training, and policy documentation. Keeling and Associates suggested three areas for improvement: better clinical integration of peer review and quality improvement activities, improving the functional capability of electronic health records, and improved communications to campus and systemwide leadership about the challenges faced by student health and counseling centers. UC Health was working to respond to all three of these recommendations.

Dr. Buchman then remarked on the implementation of UC's immunization plan, which had been phased in over the past three years. In the first year, 2015, UC focused on educating students and parents about its policy. In 2016 UC requested that students submit their documentation. As of fall 2017, the University was requiring all incoming students to submit their documentation, including documentation for screening or testing for tuberculosis, although without enforcement. He noted that UC's policy allows for medical exemptions. The University had decided to delay enforcement of the requirement for one year; while electronic health records can be shared among campuses, the student information system at each campus was different. UC was in the process of building interfaces that would allow UC to place a hold on a student's registration in cases of non-compliance beginning in fall 2018.

Advisory member Dimsdale asked if UC Health had observed any unique mental health needs among undocumented students, and how UC was addressing this. Dr. Buchman responded that UC was aware of this issue. Student health centers were asked to provide messaging to students, communicating that the centers are a welcoming and safe place to receive care. International students are also a high-risk group. UC had not captured any data on this specific question over the previous six months.

Advisory member Lipstein raised the issue of coordination between student health centers and hospital emergency departments. He remarked that an emergency room can be an intimidating environment for 17- or 18-year-old students. He asked if UC Health provides students with advocates or "surrogate parents." Dr. Buchman responded that UC clinicians are aware that many students are accessing health care by themselves, without their parents, for the first time. An advocate program for students might be desirable. Dr. Stobo added that UC Health has considered the question of how to bring student health centers and medical centers closer together, but acknowledged that little progress had been made. Committee Chair Lansing suggested that freshman orientation sessions at

UC should inform students about the presence of medical centers and emergency rooms, and how to access this care. Dr. Buchman responded that all campuses were providing this information to students, either in person or on websites.

Advisory member Ramsey asked if UC was using telemedicine services for students. Dr. Buchman responded that this approach had been developed the furthest at UC Merced, and motivated by need. The campus was unable to find psychiatry personnel within the county to provide in-person service. UC Merced has worked with UCSF-Fresno to provide telepsychiatry service to students. This effort has been successful, and UC Health was interested in expanding telepsychiatry services. These services are covered by student health insurance. Dr. Stobo emphasized that the quality of care at student health centers is outstanding.

Regent Sherman asked what percentage of student patients pay with private insurance under their parents' coverage. Dr. Buchman responded that student health and counseling centers at most campuses will see students regardless of their type of insurance. In addition, most counseling centers offer the first four to six visits free of charge. Due to budget reductions, most campus health centers have begun charging co-payments for medical visits. Dr. Buchman noted that for counseling services, the highest percentage of students make only one visit, and their needs have been addressed in that visit. He acknowledged that some students have more serious conditions or illnesses and that some need to be referred off campus.

The meeting adjourned at 2:50 p.m.

Attest:

Secretary and Chief of Staff