

The Regents of the University of California

HEALTH SERVICES COMMITTEE

August 16, 2017

The Health Services Committee met on the above date in the Plaza Room, De Neve Plaza, Los Angeles campus.

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

In attendance: Regent Guber, Regent-designate Graves, Secretary and Chief of Staff Shaw, General Counsel Robinson, and Recording Secretary Johns

The meeting convened at 2:00 p.m. with Committee Chair Lansing presiding.

1. **PUBLIC COMMENT**

There were no speakers wishing to address the Committee.

Committee Chair Lansing welcomed the meeting attendees. She noted that a recent *US. News and World Report* article ranked two UC medical centers, UCSF and UCLA, among the top ten medical centers in the nation. All UC medical centers were recognized by *US. News and World Report* as being among the best in California and the U.S.

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

Upon motion duly made and seconded, the minutes of the meeting of June 21, 2017 were approved.

3. **APPROVAL OF SALARY ADJUSTMENT USING NON-STATE FUNDS FOR PATRICIA MAYSSENT AS CHIEF EXECUTIVE OFFICER, UC SAN DIEGO HEALTH SYSTEM, SAN DIEGO CAMPUS AS DISCUSSED IN CLOSED SESSION**

Recommendation

The President of the University recommended that the Health Services Committee approve the following items in connection with the salary adjustment using non-State funds for Patricia Maysent as Chief Executive Officer, UC San Diego Health System, San Diego campus:

- A. Per policy, a market-based salary adjustment of 8.9 percent (following a systemwide three percent merit increase action), increasing Ms. Maysent's base salary to \$880,770, effective August 1, 2017.
- B. Per policy, continued eligibility to participate in the Clinical Enterprise Management Recognition Plan's (CEMRP) Short Term Incentive (STI) component, with a target award of 20 percent of base salary (\$176,154) and maximum potential award of 30 percent of base salary (\$264,231). Actual award will be determined based on performance against pre-established objectives.
- C. Per policy, continued eligibility to participate in CEMRP's Long Term Incentive (LTI) component, with a target award of ten percent of base salary and a maximum potential award of 15 percent of base salary. As the LTI uses rolling three-year performance periods, the first possible award payout would be after the end of the 2018-19 Plan Year. Actual award will be determined based on performance against pre-established objectives.
- D. Per policy, continued annual automobile allowance of \$8,916.
- E. Per policy, continuation of a monthly contribution to the Senior Management Supplemental Benefit Program.
- F. Per policy, continuation of standard pension and health and welfare benefits and standard senior management benefits (including senior management life insurance and executive salary continuation for disability after five consecutive years of Senior Management Group service).
- G. Per policy, continued eligibility to participate in the UC Home Loan Program, subject to all applicable program requirements.

The base salary described above shall constitute the University's total commitment for base salary 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 to Recommendation

The President of the University recommended approval of a market-based salary adjustment for Patricia Maysent as Chief Executive Officer, UC San Diego Health System, San Diego campus. The Health Services Committee's approval is required because this is a Level One position in the Senior Management Group (SMG).

As Chief Executive Officer for UC San Diego Health, Ms. Maysent has had many accomplishments and accolades. She oversaw the successful opening of the Jacobs Medical Center in the fall of 2016 and was the principal architect of UC San Diego

Health's strategic plan, which concentrates on four main areas: clinical excellence, patient experience, performance management, and growth. Additionally, she has managed the development of the clinical program councils and related specific clinical program strategic plans.

Throughout her time at UC San Diego Health, Ms. Maysent has been instrumental in improving the delivery of patient care by developing significant collaborations that have increased access to UC San Diego Health's services. Among them are new programs and strategic partnerships with Rady Children's Hospital and Scripps Health; an affiliation agreement with El Centro Regional Medical Center and Tri-City Healthcare District; clinical affiliations with Temecula Valley Hospital and Eisenhower Medical Center; and a joint venture with home health care provider AccentCare. In addition, Ms. Maysent has expanded the UC San Diego Health Physician Network, a collective of regional health care providers including UC San Diego Health and faculty physicians, community hospitals, medical groups, and physicians based in San Diego, Riverside, and Imperial Counties. Members of the physician network become part of a clinical integration network that collaborates on developing shared systems, infrastructure, care pathways, and quality initiatives to provide high-value health care to patients, employers, and health plans.

Ms. Maysent's extensive experience in community partnerships also resulted in UC San Diego Health partnering with high-profile organizations, such as the San Diego Chargers, the San Diego Padres, and the United States Olympic Committee. These collaborative efforts have allowed UC San Diego Health to expand services within the community and provide medical care to some of the world's greatest athletes. As Chief Executive Officer, Ms. Maysent will continue to pursue a forward-thinking approach in order to achieve positive results and position UC San Diego Health for the future – clinically, academically, and financially.

Chief Executive Officer salaries at other not-for-profit and public teaching hospitals of similar size and complexity to UCSD Health range from \$605,000 to over \$1,195,000, with a median salary of \$882,800. The comparators consist of more than 40 institutions, such as the University of Chicago Medicine, University of Massachusetts Memorial Medical Center, University of North Carolina Hospitals, Temple University Health System, and Wake Forest Baptist Medical Center.

This action proposed increasing Ms. Maysent's base salary to \$880,770, which is an 8.9 percent increase from her base salary following a systemwide merit increase (a three percent increase moving her base salary from \$785,000 to \$808,550). The proposed salary will better position Ms. Maysent, internally and externally, when taking into account the size and complexity of UC San Diego Health and Ms. Maysent's experience and qualifications. The proposed base salary will be 3.1 percent above the 25th percentile of the current Market Reference Zone. Funding for this position will continue to come entirely from UC San Diego Health System revenues and no State funds will be used.

[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.]

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

4. **APPROVAL OF SALARY ADJUSTMENTS USING NON-STATE FUNDS FOR CERTAIN MEMBERS OF THE SENIOR MANAGEMENT GROUP WITHIN THE UC HEALTH SYSTEM AS DISCUSSED IN CLOSED SESSION**

Recommendation

The President of the University recommended that the Health Services Committee approve the merit-based salary adjustments for the individuals listed below, effective July 1, 2017.

Last Name	First Name	Location	Working Title	Current Annual Base Salary	Proposed Salary Increase %	Proposed Annual Base Salary
Laret	Mark	UCSF	Chief Executive Officer	\$1,041,536	3.00%	\$1,072,782
Spisso	Johnese	UCLA	Chief Executive Officer	\$998,649	3.00%	\$1,028,608
Rice	Ann Madden	UCD	Chief Executive Officer	\$878,425	3.00%	\$904,778
Federoff	Howard	UCI	Chief Executive Officer	\$800,000	3.00%	\$824,000
Maysent	Patricia	UCSD	Chief Executive Officer	\$785,000	3.00%	\$808,550

The base salaries described above shall constitute the University's total commitment for base salary 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 to Recommendation

Consistent with the 2017 salary program for non-represented staff at all levels, the President of the University recommended approval of merit-based salary adjustments for the Chief Executive Officers (CEOs) of UC Health.

The individual CEOs have contributed greatly to the improvements and progress the UC Health organization has made over the last year, particularly in implementing operational efficiencies, securing expansion opportunities, and responding to intensified local and regional competition, among other accomplishments. For example:

- Under the guidance of UC San Diego Health System CEO Patricia Maysent, the UC San Diego Health System successfully completed the Joint Commission

accreditation review and licensing of the Jacobs Medical Center, opening in November 2016. UCSD was once again designated as part of the American Nurses Credentialing Center's Magnet Recognition Program, which recognizes superior quality in nursing care.

- UCLA Health System President and CEO – UCLA Hospital System Johnese Spisso led the successful openings of the new 168-bed California Rehabilitation Facility in partnership with Cedars-Sinai and Select Medical, the new home health care service, and the new Behavioral Health Clinic to provide mental health services to medical and graduate students. In addition, Ms. Spisso led expansion efforts with the Venice Family Clinics, Olive View, Harbor UCLA, Martin Luther King Hospital and the West Los Angeles Veterans Affairs Medical Center to provide care to vulnerable populations, and worked with L.A. Care to improve access to tertiary and quaternary care for Medicaid patients.
- In response to challenges in the reimbursement environment and Medicaid expansion, UC Irvine Health Vice Chancellor for Health Affairs and System CEO Howard Federoff implemented Operational Transformation, an initiative focused simultaneously on expense reduction, efficiency improvement, and new revenue generation, resulting in a sustainable \$39 million financial improvement and an increase of ambulatory visits to over 800,000 patients annually. Separately, UC Irvine Medical Center has also partnered with UC San Diego in an unprecedented collaboration to share a single electronic medical record (EMR) platform and information technology unit that will result in \$16 million in savings in a single fiscal year. In addition, since Dr. Federoff also serves as the Vice Chancellor for Health Affairs overseeing the Schools of Medicine and Nursing and programs in Pharmaceutical Sciences and Public Health, he led the highly successful Liaison Committee on Medical Education (LCME) accreditation site visit for the School of Medicine, securing a full eight year reaccreditation.
- UCSF Health President and CEO Mark Laret continued expansion of the UCSF brand throughout the Bay Area, solidifying a partnership with Dignity Health, one of the largest health care providers in the nation, and expanding the partnership with the accountable care network, Canopy Health, which has a network of over 4,000 physicians and 16 hospitals.
- UC Davis Health CEO Ann Madden Rice led the effort to designate UC Davis Children's Hospital as the first hospital on the West Coast and fourth in the nation to earn verification as a Level I Children's Surgery Center by the American College of Surgeons. Ms. Rice also led initiatives focusing on patient access, quality, and financial sustainability that resulted in patient engagement scores improving, patient volumes increasing, and actual financial performance significantly outperforming budget.

Expenditures for delivery of healthcare services at all five UC Health medical centers, including UCSF Benioff Children's Hospital Oakland is now in excess of \$10 billion,

more than one-third of the University's total operating expenditures. The University of California's five academic medical centers provide a vast resource for the clinical training programs of UC Health professional schools, as well as contributing, collectively, approximately a half billion dollars of their revenue to support these schools. These centers prepare future generations of health professionals; they catalyze major advances in biomedical and clinical research; and they collectively serve as California's fourth-largest healthcare delivery system, with about 42,000 employees, including 12,000 nurses. UC operates or staffs five major trauma centers, providing half of all transplants and one-fourth of extensive burn care in the state. UC medical centers manage more than 368,000 emergency room visits and nearly 4.9 million outpatient visits annually, as well as more than 167,000 inpatient admissions resulting in more than one million inpatient days. More than 60 percent of UC patients are covered by Medicare or Medi-Cal or lack health insurance. In support of the University's teaching, research, and public service missions, UC health programs also maintain active relationships with more than 100 affiliated Veterans Affairs facilities, as well as county and community-based health facilities located throughout California.

In addition, UC's institutions continue to win public accolades. The *U.S. News and World Report* 2017-18 Best Hospitals Honor Roll has UCSF Medical Center ranked fifth in the nation and Ronald Reagan UCLA Medical Center seventh in the nation, among 4,658 hospitals nationwide. Within California, UCSF was ranked first, UCLA second, Davis fifth, San Diego seventh, and Irvine 11th overall, among hundreds of institutions.

The proposed three percent increases will help the University maintain relative positioning to the salaries of CEOs at UC's peer institutions. Of the five individuals listed in the chart in the recommendation section, four have a proposed base salary that is below the 60th percentile of the current Market Reference Zone (MRZ) and one would be 1.1 percent over the 60th percentile. It is important to note that the current Market Reference Zones are based on market information that is nearly two years old; the MRZs are scheduled to be updated in March 2018. When applying more current market data, comparing each CEO to his or her peers at other not-for-profit and teaching hospitals of comparable size and complexity, all five are currently below the median (50th percentile) salary of their similar-sized counterparts with two (Laret and Spisso) around the 25th percentile. The not-for-profit and academic medical centers used in the updated market data, above, include institutions such as University of Maryland, Oregon Health and Science University, Boston Medical Center, Barnes Jewish Hospital, Johns Hopkins, Duke, University of Massachusetts Memorial, Cedars-Sinai, and University of Pennsylvania, among others.

All five individuals are eligible for incentive pay as authorized by the Regents.

Consistent with the merit program guidelines, all five individuals were in their current role on or before January 1, 2017. Four of the five individuals did not receive any salary adjustments since January 1, 2017. One individual, Ms. Spisso, received a 14 percent market-based salary adjustment effective on March 1, 2017 to begin to bring her salary

into alignment within UC Health and with CEOs at other teaching hospitals of similar size.

[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.]

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

5. 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 that Anthem Blue Cross and Blue Shield had left the California State health insurance exchange but remained in three geographic areas, in part of the San Joaquin Valley, in Santa Clara, and in all areas north of Sacramento. Peter Lee, the executive director of the exchange, had prevailed upon Anthem to stay in these three markets where there are few providers. Anthem agreed to remain in these areas only if UC agreed to be the provider of tertiary and quaternary care; the University agreed, and UC Davis and UCSF will serve as the providers. Mr. Lee thanked UC Health in writing for helping Anthem stay in these three areas.

6. OVERVIEW OF HEALTH PROFESSIONS EDUCATION FOUNDATION

[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.]

Regent Emerita and trustee of the Health Professions Education Foundation (HPEF) Cinthia Flores began the discussion by presenting a short video, a profile of Jennifer Elizondo, M.D., a family practice physician at the Edward R. Roybal Comprehensive Health Center in Los Angeles. Dr. Elizondo had grown up in East Los Angeles and her father was a migrant farm worker who never earned more than the minimum wage. She was a recipient of an HPEF Steven Thompson Physician Corps Loan Repayment Program award. She described the satisfaction of having achieved her professional goal of becoming a doctor and of serving patients in underserved communities. She emphasized the great need for primary care physicians across the U.S., especially in inner cities and rural areas.

Ms. Flores explained that HPEF is a non-profit, public benefit corporation established by the State Legislature in 1987. HPEF improves access to health care in underserved areas of California by providing scholarships and loan repayment programs to health professionals, students and graduates of medical programs who are dedicated to providing patient care in those areas. Over its 30-year history HPEF had granted about 15,000 awards with a total value of approximately \$170 million. In fiscal year 2016-17, HPEF granted 1,839 awards. HPEF had received 405 applications for the Steven

Thompson Physician Corps Loan Repayment Program and granted 91 awards for this program, totaling about \$7 million. HPEF offers six scholarship programs and seven loan repayment programs.

Ms. Flores outlined award criteria and the evaluation of candidates. The criteria vary by program, but a core criterion is cultural competency. Awardees are required to sign a contract with the Office of Statewide Health Planning and Development and to fulfill a one- to three-year service obligation. Scholarship awardees are required to provide certification of enrollment each semester or quarter. Loan repayment awardees must periodically submit verification of their outstanding debt and their employment.

HPEF seeks out the medically underserved areas of the state, and some of its programs require awardees to work in qualified facilities, such as County and State facilities, correctional facilities, Veterans Affairs medical centers, and Indian health centers. Ms. Flores briefly explained HPEF application cycles, which are open for about a two-month period.

The Steven Thompson Physician Corps Loan Repayment Program is one of the largest HPEF programs. Funding for this program comes from a \$25 licensing fee from the Medical Board of California and Osteopathic Medical Board of California, as well as \$1 million from the Managed Care Administrative Fines and Penalties Fund and \$4 million from the California Endowment. At least 80 percent of the physicians who received a program award in 2016-17 are primary care physicians. There have been about 1,300 awardees since the inception of the program.

Funding for HPEF's scholarship and loan repayment programs comes from State licensure renewal fees and grants: HPEF has a \$31 million grant from the California Endowment, a \$150,000 grant from the California Wellness Foundation, and a \$1.5 million grant from the California Medical Services Project. HPEF is also pursuing individual and foundation philanthropy. Ms. Flores concluded by expressing the hope that HPEF and the University would develop a stronger collaboration and partnership, and that UC medical students would become increasingly aware of the HPEF programs available to them.

Regent Makarechian asked how HPEF makes decisions about the allocation of award funding among its various programs. Ms. Flores responded that these decisions are based on the source of grant funding, the entity providing the funds. Some licensure fees are directly tied to specific programs.

Chair Kieffer asked how HPEF communicates about its programs to UC schools. Ms. Flores responded that HPEF carries out UC site visits and would like to develop a more targeted effort.

Advisory member Hernandez asked if HPEF had a plan for sustainable funding for its scholarship and loan repayment programs in the face of diminishing philanthropic support from California health foundations. Ms. Flores responded that HPEF was actively

pursuing innovative ways to develop sustainable revenue, cultivating founders and donors who have assisted HPEF in the past, and approaching foundations that had not yet supported HPEF. HPEF was also pursuing individual giving as a revenue source. This year HPEF launched its first online apparatus for donations.

Committee Chair Lansing stated that there was a need for greater awareness of the existence of this program and that UC Health should work with HPEF toward this goal.

7. **UC HEALTH AFFILIATIONS: REPORT ON QUALITY STANDARDS FOR BRAND EXTENSION**

[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 introduced the discussion, which was animated by two questions faced by UC Health in its clinical affiliations, mergers, and acquisitions: how should UC Health set minimum quality requirements that allow it to extend its brands to potential partners or affiliates, and what brand guidelines and framework should guide UC Health? UC Health had convened two groups to consider these questions.

UCSF Health Chief Executive Officer Mark Laret touched on the risks and benefits of UC Health affiliations with non-UC hospitals, physicians, and other providers. He presented the growth of the UCSF Health network from 2014 to 2017 as an example of aggressive growth at UC Health. The potential risks of extending the UC brand include false expectations patients may have about the actual care experience, reputational risks when an affiliate fails to live up to UC standards of quality, safety, or patient access, and the financial liabilities of an affiliate. An important benefit of such affiliations is that they extend UC's ability to provide access to tertiary and quaternary care. Mr. Laret described specialty care as the financial lifeblood of UC's academic medical centers. These high-margin services help distinguish the University and lead to high rankings, and there is increasing competition for specialty care patients. Another important area of focus for UC Health is the development of population health programs, and UC needs to form affiliations with primary care physicians and low-acuity hospitals in pursuit of this effort.

Mr. Laret outlined some basic principles of UC Health affiliations and noted that there are various reasons for these affiliations, including the wish to improve the quality of poorer-performing hospitals and the need to maintain a strong market position in the face of competition. For each potential affiliation, UC Health would carry out quality and brand due diligence, would extend the UC brand only with clear guidance, and would actively monitor performance.

UCSF Chief Medical Officer Joshua Adler remarked that UC Health approached this work in light of its own internal quality dashboard. There are minimum quality requirements for any hospital affiliation: licensure by the California Department of Public Health, and good standing with the Joint Commission and the Centers for Medicare and Medicaid Services. UC would carry out its own review of the external regulatory

agencies' accreditation and evaluation reports, which are not public documents. Medical directors appointed in these affiliations would have some accountability to a UC physician to oversee quality. There must be a governance structure for measuring and improving quality. UC would make use of validated external rankings as well as its own dashboard criteria.

Quality standards would be slightly different for physician affiliations. The core criteria have to do with individual physicians and practices. Board certification is a minimum requirement. A physician practice must have electronic health records or plans to adopt such records. In addition, specialty-specific benchmarks must be developed with UC faculty. Dr. Adler then adumbrated other types of affiliations UC Health might enter into for services UC Health generally does not provide, such as nursing home care, standalone imaging centers, and urgent care; for these types of affiliations there would have to be a similar quality of due diligence.

Following UC Health's due diligence on a potential affiliate, that affiliate might fall short on one criterion or another. In those cases, the affiliate might be granted a "provisional status" to allow time to implement plans for improvement. If the standards are achieved, the affiliate would move from provisional to official affiliate status. The same would be true for any existing UC Health partner, in case its performance deteriorates in some way; a formal process improvement plan would be required.

UCSF Senior Vice President Shelby Decosta explained that an approach like that for quality assessment was also applied to brand assessment. Due diligence would consider a brand's positioning in the market, social media presence, consumer preference data, professional reputation, and awards and rankings. Once an affiliate meets the quality and brand requirements, each UC location would ensure that any use of UC's brand supports UC's principles and values, claims made in advertising are factual, there is no conflict with the University's public mission, and use of the UC brand accurately reflects the relationship in the affiliation. UC Health was developing templates for clear expectations about how the brand is to be used, including typography and placement of logos. Each campus is responsible for ensuring that affiliates adhere to these standards.

Regent Sherman asked if the University had considered using "UC Health" as a single brand rather than having each medical center with its own brand. Mr. Laret responded that in individual markets, the local medical center brand has more weight than UC Health as a brand. Dr. Stobo compared this situation to that of Procter and Gamble, whose individual products have their own reputation and brand; but for some issues and questions, the Procter and Gamble brand is important. The UC Health brand might be significant in dealing with the Legislature or in pursuing partnerships with some outside entities. UC Health does not wish to usurp or diminish a local brand. In most cases, these brands are dominant in the local market. At the same time, UC Health is actively pursuing better integration as a unified health system. Committee Chair Lansing commented on UC Health's remarkable progress in this effort.

Advisory member Lipstein remarked on tensions that exist between not-for-profit organizations and for-profit enterprises and recalled instances when universities have entered into affiliations with for-profit companies. Branding a not-for-profit organization together with a for-profit entity raises the issue of whether an organization like UC should continue to enjoy the special privileges associated with not-for-profit health care. He asked if the UC Health working groups had addressed branding concerns associated with this difference between for-profit and not-for-profit entities. He noted that for-profit companies might easily meet the quality standards just discussed. Mr. Laret responded that UC Health should further examine this question and noted that for-profit companies are sometimes the only providers of certain services in a given area. UCLA Health President Johnese Spisso added that UCLA Health, Cedars-Sinai, and Select Medical formed the California Rehabilitation Institute, which does not use the UC brand. UCLA patients are admitted to the Institute, and UCLA provides some medical direction and quality oversight, but UCLA does not lend its brand. Mr. Lipstein stressed that UC would need to address this branding issue, and the question of enjoying a tax-exempt status while engaged in the same activities as a for-profit enterprise. Dr. Stobo concurred that this is an important consideration.

Regent Blum questioned the goal of affiliations, stressed that UC Health is not a franchise business, and asked about the depth of knowledge that UC has about its affiliates and about the real financial benefits to UC of these affiliations. He expressed his view that UC Health should pursue affiliations on a limited basis. Mr. Laret responded that the UC medical centers' own preference would be to avoid partnerships, but changes of great magnitude had taken place in the past decade. The market environment had become extremely competitive. UCSF was receiving fewer referrals. Financial viability and the volume of patients necessary to maintain high quality were in jeopardy. Affiliations such as UCSF's with Washington Hospital Healthcare System in Fremont result in additional case numbers for UCSF specialists, improving financial strength and faculty recruitment and retention. The Affordable Care Act had also brought about significant changes and provided an impetus for UC Health to focus on population health. UC medical centers offer excellent specialty care and can address important aspects of population health, but not the totality of needs. For these reasons, UC medical centers participate in networks.

In response to a remark by Regent Blum, Committee Chair Lansing emphasized that quality is the most important consideration for UC Health in these affiliations. Reaching underserved communities is also an important part of UC Health's mission.

Advisory member Hernandez observed that in primary and specialty care, and particularly in specialty care, quality and volume go together. It is difficult to maintain high quality standards with low patient volume. In the current market, the ability to reach other networks would help maintain the quality of UC Health, particularly in its subspecialty areas. In research literature on this topic, volume of referrals and quality are seen to be closely aligned. A medical center cannot maintain its quality with a diminishing patient base.

Regent Sherman asked why volume is needed to maintain quality. Dr. Hernandez responded that UC medical centers are presented with many unique cases. UC physicians and researchers try to learn from these cases and communicate and document knowledge about them in the scientific literature. With a lower patient volume, there are fewer opportunities to gain such knowledge and experience. Patients needing a certain procedure prefer to be treated at a hospital with more experience in performing this procedure.

Regent Sherman stated that this point served as an argument for promoting UC Health as a single brand rather than as many separate entities.

Dr. Hernandez referred to the developing field of population health, a field in which there is not yet a top expert. In considering the next horizon of excellence for UC Health, the system should aim for mastery of population health. Amassing and sharing large amounts of patient data would be a part of this effort.

8. **UCLA HEALTH BUDGET OVERVIEW, LOS ANGELES 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.]

UCLA Health Sciences Vice Chancellor John Mazziotta reported that UCLA Health's financial performance had been strong and consistent. The most recent financial results had exceeded the planned and budgeted performance. Key factors in this performance were strong operating revenues, high inpatient volume, supplemental Medi-Cal and Medicaid funding in the last year, and cost control. Nevertheless, revenue was not keeping pace with the growth of expenses. The UCLA School of Medicine is dependent on financing from the UCLA Health System and Dr. Mazziotta anticipated that it would come under stress as the Health System's margins decline.

Dr. Mazziotta presented a chart illustrating the organizational structure of UCLA Health Sciences. UCLA Health was shown as a division within UCLA Health Sciences. UCLA Health consists of the Health System, hospitals and clinics, which generate about \$2.5 billion annually, the David Geffen School of Medicine, which generates approximately \$1.1 billion annually, and the UCLA Faculty Practice Group, which generates about \$1.3 billion. The Schools of Dentistry, Nursing, and Public Health were shown as another division within UCLA Health Sciences, with annual pooled income of about \$0.2 billion. The rest of the UCLA campus, outside UCLA Health Sciences, had a revenue base of \$2.5 billion.

Dr. Mazziotta presented a second chart that elucidated the interdependence of UCLA's hospitals, its faculty practice group, and its School of Medicine. A third chart further subdivided the UCLA hospitals and the faculty practice group into their constituent entities and identified UCLA's strategic affiliations with Los Angeles County hospitals, Veterans Affairs facilities, Miller Children's Hospital, Martin Luther King Community

Hospital, Venice Family Clinic, Charles R. Drew University, and the California Institute of Technology.

UCLA Health revenue represented 65 percent of campus revenue and it is clearly critical for the well-being of the campus. Dr. Mazziotta presented projected financial figures for fiscal year 2017, which exceeded budget in the categories of average daily census, outpatient visits, revenue, earnings before interest, depreciation, and amortization (EBIDA), net income, days' cash on hand, and debt service coverage ratio. For fiscal year 2018, UCLA was projecting a slight decline in average daily census due to renovations in UCLA's four hospitals. Outpatient visits and revenue were projected to increase, while EBIDA and net income would decline. The reasons for this decline were that a one-time infusion of \$63 million in Medicaid and Medicare funding in the past year would not be repeated and that UCLA was anticipating the termination of the Anthem health insurance exchange contract in January 2018, which would have a major impact on UCLA Health revenue. Days' cash on hand would decrease due to the need to draw on reserves for capital equipment renewal.

Dr. Mazziotta presented information on more than 1,200 UCLA physicians working in Veterans Affairs, County, or other outside facilities. UCLA has relationships with 12 community hospitals, where UCLA hospitalists oversee patient care. UCLA Health provides approximately \$334 million in community benefit annually. A large portion of this benefit, about \$250 million, reflects Medicaid care, since UCLA Health is typically able to collect only 50 cents per dollar for Medicaid patient care.

UCLA Health would face a number of challenges in the coming years. The Anthem insurance exchange contract termination would have an impact of \$144 million. UCLA would make a significant attempt to backfill the loss of these patients and to determine which patients could continue to receive medical care at UCLA with other payers. The projected revenue loss of \$144 million was a worst-case scenario. In addition, other regulatory and payment reform changes were taking place or would soon take place and their effect on UCLA was not yet known. These included the Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act of 2015, the uncertain state of the Affordable Care Act, possible reductions in Medicare funding for medical resident education, and potential Medicaid reductions. Dr. Mazziotta concluded his presentation with a chart showing a steady yearly increase in Medi-Cal patients at UCLA since implementation of the Affordable Care Act.

Regent Makarechian referred to the financial figures shown and asked why EBIDA and net income were projected to decrease in fiscal year 2018, net income by \$104 million. UCLA Health Senior Vice President Paul Staton responded that this was due primarily to the fact that one-time revenue of \$63 million in fiscal year 2017 would not be available in 2018, and to the loss of the Anthem contract. Overall rate increases in UCLA's insurance products were at two to three percent, while costs were increasing by about seven percent.

Regent Makarechian asked why revenue was projected to increase slightly while net income would decrease substantially. Mr. Lipstein explained this through inflation of expenses, even while revenue was growing. Mr. Staton added that all UC medical centers were expecting revenue growth in the range of two to three percent, while expenses grow by about seven or eight percent, attributable to increasing wages and expense inflation for pharmaceuticals and supplies.

Regent Blum asked about UCLA Health's five-year outlook. Mr. Staton responded that UCLA has strategic plans to close its budget gap. The budget for the next year was very conservative, anticipating no backfill for the loss of the Anthem contract, although UCLA was assuming that most of its Anthem patients would move to another plan with which UCLA has contracts and that there would be some additional Medicaid funding. UCLA was pursuing operating efficiencies and alternative revenue streams.

Regent Blum asked that UCLA Health present its budget strategies at a future meeting. Dr. Mazziotta observed that UCLA's strategies addressed both revenue and expenses. In past years, UCLA had faced difficult budgets like this one and had managed to fill budget gaps. Capital equipment replacement costs of \$100 million and the absence of one-time payments of \$63 million together had produced a dramatic effect on this budget.

Regent Sherman asked to what extent UCLA Health expenses are variable, based on patient volume. He asked if UCLA was operating at a loss and trying to make up for this in volume, or if UCLA had a contribution margin. Dr. Mazziotta responded that UCLA did not have capacity to increase inpatient volume, and this was probably the case for all UC inpatient facilities. The increase in Medicaid patients as a percentage of all paying inpatients has caused a deterioration in the margin. UCLA has 160 outpatient clinics, and these clinics have capacity, fixed overhead costs, and opportunities to increase revenue. Efficiencies in UCLA's inpatient hospitals would have to come from greater numbers of patients treated and from length of patient stays.

In response to a question by Regent Sherman, Mr. Staton confirmed that UCLA Health's debt service coverage ratio and days' cash on hand were above the minimum required UC thresholds. Dr. Mazziotta added that there are many expenses UCLA cannot control, such as labor, pension, and Other Post-Employment Benefit costs. Payroll costs as a percentage of total costs are increasing, from about 49 percent a few years earlier to 60 percent. Regent Makarechian asked about the causes of this increase. Executive Vice President Stobo responded that the increase was attributable mostly to negotiated labor contracts.

In response to a question by Mr. Lipstein, Dr. Stobo responded that the \$44 million in net income projected for fiscal year 2018 represented the amount before funds are contributed to the School of Medicine. Mr. Lipstein noted that net income was also projected to decrease by \$104 million and asked if this would reduce funds flowing to the School of Medicine. Dr. Stobo responded that so far, systemwide, decreasing margins had not resulted in reductions in support for UC's medical schools. Mr. Lipstein observed that as pressure is put on operating margins without a reduction in funds flowing to the

medical schools, hospitals may be undercapitalized or find themselves without sufficient cash flows to renew patient care infrastructure.

Committee Chair Lansing stated that this situation needed to be monitored. Observing that the UCLA hospitals are always at capacity for inpatients, she asked if UCLA was contemplating building a new hospital. UCLA Health President Johnese Spisso responded that UCLA was always examining ways to expand patient capacity, but there were also opportunities for increased efficiencies, reducing the length of patient stays, and increasing the number of patients seen.

Regent Makarechian asked if the capacity problem was unique to UCLA or true of all UC medical centers. Drs. Mazziotta and Stobo responded that all UC medical centers are at capacity. Ms. Spisso added that UCLA is addressing this issue through its partnerships with community hospitals. Patients needing tertiary or quaternary care are transferred to the Westwood or Santa Monica hospitals.

Regent Makarechian asked about the most critical need to be addressed for UCLA Health. Ms. Spisso responded that UCLA Health would take a variety of measures to address its budget gap; for example, in its approach to the acquisition of goods and services. Given rising pharmaceutical costs, UCLA was developing standard formulary management and seeking efficiencies in generic substitution.

Dr. Mazziotta referred to Mr. Lipstein's earlier comment on pressure on medical center operating margins. In order to increase revenue for the School of Medicine and reduce pressure on the medical center, UCLA was pursuing intellectual property revenue, philanthropy, and increased funding through contracts and grants. UCLA Health must not try to help one of its entities at the expense of the others.

Dr. Stobo added that UC Health's expenses increase by 13 percent annually systemwide, while revenues increase by nine percent. Six percent of the increase in expenses is accounted for by labor costs, over which the University has little control, while seven percent is due to supplies, an area where UC can make efforts to reduce expenses.

Committee Chair Lansing asked that UCLA present its budget strategies at a future meeting and expressed optimism that its budget situation might improve.

The meeting adjourned at 3:35 p.m.

Attest:

Secretary and Chief of Staff