

## TEACHING HOSPITALS

<b>2001-02 BUDGET</b>	
<b>Total Funds</b>	<b>\$ 2,732,506,000</b>
General Funds	52,437,000
Restricted Funds	2,680,069,000
<b>2002-03 INCREASE</b>	
General Funds	--
Restricted Funds	53,505,000

### **The Role of the University Teaching Hospitals**

The University of California owns and operates five academic medical centers—Davis, Irvine, Los Angeles, San Diego, and San Francisco. Their primary mission is to support the clinical teaching programs of the five schools of medicine and the educational programs in the University's other health sciences schools (e.g., dentistry, nursing, and pharmacy). In addition to supporting the clinical teaching programs, the academic medical centers provide a full range of health care services in their communities and are sites for the development and testing of new diagnostic and therapeutic techniques. Three of the hospitals are former county hospitals and are the safety net providers in their counties. The University of California's academic medical centers are a major resource for California and the nation as they perform their tripartite mission of teaching, research and public service.

The core clinical experiences for health science students occur at the five academic medical centers and at a variety of affiliated teaching sites. The medical centers support a broad range of educational programs for medical students, postgraduate physicians (interns and residents), practicing physicians in the community, nurses, and allied healthcare professionals, preparing them for current and future healthcare needs. The medical centers provide all levels of care from primary to quaternary. In response to changes in the financing and delivery of health care, and as the result of the

University's efforts to expand training opportunities in primary care, the medical centers have developed more outpatient clinical training sites and primary care networks.

The UC medical centers conduct basic and clinical research which are essential to continued advancement in the understanding and treatment of diseases and the improvement in the health status of the population. Research projects include clinical trials of investigational drugs, devices and medical procedures, as well as, epidemiological studies that contribute substantially to the general public's well-being and to the education and patient care missions.

The University's academic medical centers comprise one of the largest health care systems in California and one of the largest Medi-Cal providers in the State.

In 2001-02, the University medical centers will have a combined licensed capacity of 3,490 beds and are expected to generate more than 773,000 patient days and more than 3.6 million visits.

The five UC medical centers have different histories and serve unique roles in their communities. Prior to the 1960s, the University had two medical schools, one at San Francisco and one at Los Angeles. The University owned and operated teaching hospitals on both campuses in fulfillment of its mission to educate medical students and residents in a clinical setting. Both medical schools also had affiliation arrangements with county, Veterans Affairs, and other hospitals to provide educational experiences for the campus' medical students and residents.

In the 1960s, the decision was made to develop three new medical schools at the Davis, Irvine, and San Diego campuses. The University's plan was to repeat the San Francisco and Los Angeles models with on-campus teaching hospitals and affiliations with county, Veterans Affairs, and other hospitals. However, while supporting the University's education and research efforts, the Legislature wanted the University to give a higher priority to providing medical care for the poor. Therefore, the Legislature provided resources to purchase three existing county hospitals and to initiate capital projects to renovate the facilities to make them more suitable for the University's education, research, and patient care missions.

## **Financial Issues Facing the Teaching Hospitals**

Throughout their history, the three former county hospitals have provided care to a disproportionately high percentage of Medi-Cal patients and the uninsured. Since most of these services are government-financed, these medical centers are vulnerable to changing public policies related to the funding and provision of health care for the poor. They continue to be the “safety net” provider in their respective counties, and rely heavily upon supplemental payments from Medi-Cal disproportionate share programs.

The UCLA and UCSF Medical Centers are also struggling with financial issues. While they don’t serve as “safety net” providers in their counties, they are more dependent upon Medicare and contract payors for reimbursement than Davis, Irvine and San Diego Medical Centers. The market forces related to increases in managed care have resulted in declining revenues per patient. The financial impact of declining revenues are intensified by dramatic increases in labor, pharmaceuticals, energy and other operating expenses. Although the UCLA and UCSF Medical Centers serve many Medi-Cal patients, they don’t qualify as disproportionate providers and are ineligible for Medi-Cal disproportionate share supplemental payments.

While the University’s medical centers face financial challenges similar to other hospitals trying to survive in a price-sensitive managed care environment, they have added responsibilities related to their function as academic institutions. The costs associated with new technologies, biomedical research that has the potential to improve lives, the education and training of health care professionals, and provision of care for a disproportionate share of medically underserved Californians make it difficult for the UC medical centers to compete with providers that do no teaching or research. While academic medical centers receive some compensation for teaching costs from government payors, including Medicare and Medi-Cal, it is below actual costs. Also, the level of compensation does not include teaching costs incurred in outpatient settings. No other payors (i.e., commercial, contract, county, etc.) recognize the added costs of teaching in their payment to academic medical centers. Therefore, one of the University’s highest priorities is to ensure that the medical centers have a dedicated and sustained source of funding to support graduate medical education.

The financial viability of UC medical centers directly affects the quality of the instructional programs at the University’s Schools of Medicine. Schools of

Medicine are heavily dependent upon revenues generated from patient care by the medical centers and faculty practice plans. Financial support from the academic medical centers enables the Schools of Medicine to recruit and retain good faculty, as well as expand existing and create new academic programs, and support primary care initiatives. Therefore, the medical centers must generate sufficient funds for their operational and capital needs, as well as for their respective Schools of Medicine and primary care networks.

Since managed care has become the primary system for delivering and financing health services, the University has experienced a shift in the delivery of services, with the major growth occurring in outpatient settings. Market forces have required that the UC medical centers accept negotiated rates from private and some public payors that do not recognize educational costs. Like all hospitals, the University's academic medical centers were affected by the Balanced Budget Act (BBA) of 1997, and the Balanced Budget Refinement Act (BBRA) of 1999, that were designed to slow future rate increases in Medicare and Medicaid. In addition to reduced Medicare reimbursement for patient care to all Medicare providers, reimbursement to academic medical centers has been severely cut by the changes in federal Medicare medical education funding.

Over time, the University's medical centers have pursued with the State both short-term and long-range solutions to address fiscal challenges and avert significant losses. State-funded capital and operating subsidies were provided to the three former county hospitals in the mid-1980s to assist them in reaching a broader patient base. Special supplemental funding is being provided by the State to all California hospitals, including UC's three former county hospitals, that treat a disproportionate share of Medi-Cal and other low-income patients. In addition to the federal Medicare program, which recognizes the costs of medical education, the University began using State Clinical Teaching Support (CTS) funds in 1997 to leverage additional federal Medicaid dollars to support educational costs incurred in providing services to Medi-Cal patients. More recently, the State provided one-time funds in 2000-01 for equipment (\$25 million) and infrastructure (\$50 million), and authorized lease revenue bonds for seismic needs (\$600 million). The State provided a one-time augmentation in 2001-02 for Clinical Teaching Support (CTS) that will be shared among medical centers, the neuropsychiatric institutes and the dental clinics. This augmentation was provided in recognition of CTS budget cuts in the early 1990s. Throughout the history of UC's teaching hospitals, State assistance has been vital to their financial

stability and therefore has had a beneficial impact on the hospitals' ability to conduct their teaching mission and provide patient care.

The medical centers have taken steps to remain competitive in their respective markets by holding down costs and by expanding their presence in the market through affiliation with physician groups or the addition of hospital sites. As part of their strategy to capture greater market share and to improve their patient mix, three of the UC medical centers expanded their patient care by adding hospitals at different locations. In 1990, Mount Zion Health Systems integrated with UCSF Medical Center; in 1993, UCSD built the Thornton Hospital on the La Jolla campus; and the UCLA Medical Center acquired the Santa Monica Hospital in 1995.

The financial viability of the University's medical centers depends upon a dedicated and sustained source of funding to support medical education and care for the poor, as well as payment strategies that recognize the need to maintain an operating margin sufficient to cover debt, provide working capital, purchase state-of-the-art equipment, and invest in infrastructure and program expansion. In recent years, there has been considerable legislative interest in and recognition of the financial difficulties facing the University's medical centers. Some of this interest has been generated by concerns over the University's ability to provide health care to the State's indigent population as the medical centers pursue long-term strategies to ensure their fiscal viability while supporting the University's academic mission. Another major concern is compliance with SB 1953, the Hospital Seismic Safety Act, which requires acute care hospitals to ensure that their facilities can maintain uninterrupted operations following a major earthquake.

The remainder of this chapter reviews the major sources of funding for patient care and teaching, changes in the financing and delivery of health care that have occurred over the past decade, and the challenges that lie ahead.

### **Funding for Patient Care**

The University's medical centers are paid for services provided to patients. The major sources of patient revenue are government-sponsored health care programs (i.e., Medicare, Medi-Cal and the California Healthcare for Indigents Program); commercial insurance companies (i.e., managed care contracts and private insurance); and self-pay patients. Several government-sponsored programs provide supplemental payments in

recognition of the role the UC medical centers play in providing a disproportionate share of care to the State's indigent population.

### ***Medicare***

The federal Medicare program (Title XVIII of the Social Security Act) is a third-party payor managed by the Social Security Administration that underwrites the medical costs of persons 65 years of age and older, and persons under 65 who are disabled or have end-stage renal disease. Inpatient acute care services provided to Medicare beneficiaries are paid at prospectively determined rates, which vary according to a patient's diagnosis. Inpatient non-acute services, certain outpatient services and medical education costs are paid, based in part, on a cost reimbursement methodology. Effective August 1, 2000, Medicare implemented a prospective payment system for hospital outpatient care – the Ambulatory Payment Classification (APC) - in an attempt to hold down rising costs in such settings.

The Medicare population is an important segment of the patient mix seen at UC medical centers; and it will become increasingly important as a large portion of the nation's population lives longer.

In 2000-01, the number of Medicare days were 201,986, representing approximately 26.5% of total patient days. The Medicare program generated \$659.1 million of net operating revenue, accounting for approximately 24.1% of the total net operating revenue of the UC medical centers.

### ***Medi-Cal***

Medicaid, known as Medi-Cal in California, is a State-administered third-party payor designed to reimburse medical costs of the medically indigent and those on certain public welfare programs, such as Aid to Families with Dependent Children (AFDC) and Supplemental Security Income for the aged, blind, and disabled. Inpatient services provided to Medi-Cal beneficiaries are paid under a contract at a prospectively determined, negotiated per-diem rate. Reimbursement for outpatient services is based on prospectively determined fee schedules.

In 1982 the California Legislature established the Selective Provider Contracting Program (SPCP). The program operates under a federal waiver in accordance with Section 1915 (b) (4), Title XIX, of the Social Security Act. The SPCP has worked to provide adequate access to hospital services for

Medi-Cal beneficiaries, while at the same time achieving significant savings over the traditional “cost based” reimbursement system. In addition to the SPCP, Medi-Cal implemented managed care programs in 1994.

In 2000-01, the number of Medi-Cal days were 172,157, representing 22.6% of total patient days. The Medi-Cal program generated \$430.9 million of net operating revenue, accounting for approximately 15.8% of the total net operating revenue of the UC medical centers.

### ***Supplemental Medi-Cal Payments***

**SB 1255 Funds.** In 1989-90, the State established the Disproportionate Share and Emergency Services Fund, also known as the SB 1255 program. Through the SB 1255 program, public agencies that own eligible disproportionate share hospitals, including the University, voluntarily transfer funds to the State. These funds are used to secure federal Medicaid matching funds. The pool of funds is then distributed by the State to public and private hospitals that treat a disproportionate share of Medi-Cal and low-income patients. The Davis, Irvine, and San Diego Medical Centers qualify as disproportionate share providers. The distributions result from negotiations between the University and the California Medical Assistance Commission (CMAC).

From May 1990 to June 2001, the University received about \$232.7 million in new federal funds from this program. The continuation of this program, which has been a significant source of funding for the Davis, Irvine, and San Diego Medical Centers, is uncertain in light of federal attempts to constrain Medicaid’s growth. The elimination of the SB 1255 program would mean the loss of about \$50 million a year for the eligible UC medical centers.

**SB 855 Funds.** In 1991-92, the State created a second vehicle, known as the SB 855 program, to provide supplementary payments to hospitals providing a disproportionate share of their inpatient services to Medi-Cal or other low-income patients. In 2000-01, the University received approximately \$60.7 million in SB 855 funds, accounting for about 4.6% of the total net patient revenue at the Davis, Irvine and San Diego Medical Centers. From

1991-92 through 2000-01, the University received about \$509 million in new federal funds from this program.

The SB 855 program requires governmental entities, such as counties, hospital districts, and the University, which own eligible disproportionate share hospitals, to make mandatory transfers to the Department of Health Services (DHS) for deposit into the Medi-Cal Inpatient Payment Adjustment Fund. Unlike the SB 1255 program, these are mandatory transfers, the levels of which are determined by formula. These funds are used to secure matching federal Medicaid dollars. The pool of funds is then distributed by the DHS to all public and private disproportionate share hospitals. The distribution of SB 855 funds is derived by a formula based on the previous year's data regarding the number of Medi-Cal days and the percentage of other low-income beneficiaries served.

Beginning in 1993-94, distributions from the SB 855 program were subject to federal provisions which set a ceiling on the distributions that could be made to individual hospitals and, cumulatively, to each state. This ceiling is referred to as a hospital's OBRA CAP. All Medi-Cal reimbursement, including SB 1732 – capital funds for Medi-Cal disproportionate share hospitals, the Medi-Cal Medical Education funds and SB 1255 are factors in determining a hospital's OBRA CAP. The SB 1732 and the Medi-Cal Medical Education programs are described later in this section.

In 1999-2000, the net benefit to eligible disproportionate share hospitals was approximately \$20 million less than the amount received in 1998-99 because the total amount of federal funding available to the State of California decreased. The decrease was due to a combination of factors, including a reduction in Medi-Cal days and Medicaid cuts in the Balanced Budget Act of 1997. The total number of Medi-Cal inpatient days across the State is declining as managed care plans exert tighter controls on admissions and length of stay. The number of inpatient Medi-Cal days will decrease further if legal and illegal immigrants are removed from the Medi-Cal rolls as a result of federal welfare and immigration reform. A continued decrease in Medi-Cal patients hinders the University's clinical teaching programs, and could limit the University's ability to participate in the SB 855, SB 1255, and SB 1732 programs. The Balanced Budget Refinement Act of 1999 ensured SB 855 funding by not only extending indefinitely the sunset date for high disproportionate share hospitals, but also by redefining high disproportionate share hospitals to include all public disproportionate share hospitals which are all capped at 175% of costs. All three UC disproportionate share hospitals qualify under the 175% OBRA CAP.

## ***Tobacco Tax Funds***

In November 1988, voters approved Proposition 99, which imposed an additional tax on cigarettes and other tobacco products. Proposition 99 created six separate accounts from which funds are appropriated for specific purposes, including indigent care, the prevention and cessation of tobacco use, and the prevention and treatment of tobacco-related diseases. Funds from the “Hospital Services and Unallocated Accounts” are available for payment to public and private hospitals for treatment of patients who cannot afford to pay, and for whom payment will not be made through private coverage or by any program funded in whole or in part by the federal government.

In 1989, the State approved a plan (AB 75) specifying how Proposition 99 funds were to be distributed. Since 1989, there has been a decline in smoking and in the use of other tobacco products, which has reduced the total amount of Proposition 99 funds. In 2000-01, the University medical centers received a total of \$2.9 million as compared to \$14.6 million in 1989-90. The amount of Proposition 99 funds in 2001-02 is projected to remain fairly constant over the next few years, about \$3 million. Although the amounts have declined over the years, these funds are an important source of revenue for indigent care at the UC medical centers.

## ***Changes in Health Care Financing***

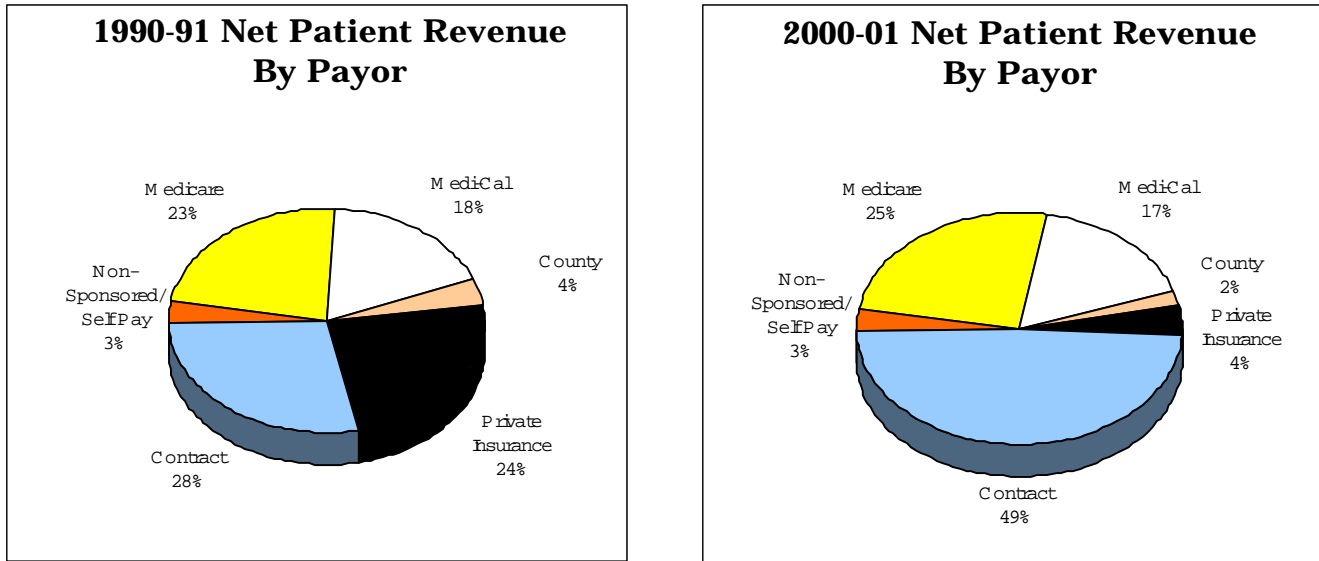
Rising health care costs in the 1980s, demographic changes, and changing economic conditions caused the State, the Congress, and the private sector to initiate fundamental changes in the financing of health care services.

The traditional fee-for-service reimbursement system has been almost completely replaced by competitively established fixed-price payments, (i.e., capitated, per-diem, or global rates by diagnosis). As a result, costs unique to academic settings (e.g., treating sicker patients, providing services to a disproportionate number of uninsured or under-insured patients, and providing a medical education in a clinical setting) are not fully reimbursed. In addition, the loss of fee-for-service or cost-based reimbursement in the private sector has eliminated the opportunity to cover some of these costs through cross-subsidization.

Over a ten-year period, 1990-91 through 2000-01, the percentage of net patient revenue from patients covered by fee-for-service (i.e., private payors) decreased from 24% to 4%, while net patient revenue from patients covered by contractual or capitated arrangements increased from 28% to 49%. The

slight decrease in the percentage of Medi-Cal net patient revenue is due to Medi-Cal managed care days being reported as contract days because of their similarity in payment arrangements.

Display 1



Changes in health care financing that have negatively affected the medical centers began in 1982, when reforms of the State Medi-Cal program instituted selective hospital contracting for inpatient services at flat per-diem pricing, stricter eligibility requirements, and the transfer of responsibility for the Medically Indigent Adults (MIAs) from the State to the counties (funding for the MIAs was provided at less than the 70% of projected State expenditures for the base year 1982-83). The transfer of the MIA patients directly affected the three former county hospitals—Davis, Irvine, and San Diego—because the local tax dollars used to subsidize hospitals operated by local government were not available to University-operated medical centers.

In 1982, private health care insurers were provided, through legislation, with the same ability as the State to contract selectively with health care providers on behalf of their enrollees.

At the same time, changes in federal Medicare payment policies for hospitals included a prospective payment system for inpatient care based on payments-per-case according to Diagnosis Related Groups (DRGs), rather than on actual hospital costs. These changes, also, limited payments for teaching costs and phased out cost-based payments for capital improvements. Effective August 1, 2000, outpatient care provided to Medicare patients was

changed from cost-based reimbursement to a prospective payment system, which uses the ambulatory payment classification system.

In the early 1990s, DHS was given authority to hasten the transition of Medi-Cal from a fee-for-service to a managed care system for approximately 2.5 million Aid to Families with Dependent Children (AFDC) beneficiaries. Under these managed care programs, the provider agrees to treat Medi-Cal enrollees for a fixed rate-per-member-per-month; thereby, the provider is at risk and is liable for any expenses incurred beyond the monthly capitation payments. The University's medical centers are at increased financial risk for managing the care of patients covered under these managed care programs. The type and the size of the Medi-Cal managed care programs varies among counties.

### ***Special Subsidies for the Three Former County Hospitals***

The 1985 Budget Act authorized the Legislative Analyst to contract for a study of the effectiveness of the management of the three former county hospitals operated by the Davis, Irvine and San Diego Medical Centers. In April 1986, the consultant reported that management of the three hospitals was effective and that their operating losses were fundamentally attributable to the environment in which they must operate. The consultant also emphasized that the fiscal survival of these hospitals would depend upon a State-funded operating subsidy to help cover their significant volume of uncompensated and undercompensated patient care. The outcome of a management review of the operations of the three medical centers resulted in an agreement with the State. As a result of that agreement, the State provided \$86 million to fund cost-saving and revenue-enhancing capital outlay projects and equipment purchases, and \$28.6 million to mitigate operating losses. The Irvine Medical Center received all of the \$28.6 million operating subsidy because it was the only UC medical center that incurred losses.

### ***Meeting the State and University Budget Shortfalls***

In the early 1990s, in recognition of the fact that the State provided more than \$80 million of assistance by funding needed capital improvements at the three former country hospitals during the 1980s, the University and the State turned to the medical centers to help alleviate some of the University's budgetary problems. At that time, the University was experiencing unprecedented cuts in its operating budget and the academic medical centers were experiencing modest gains.

In 1992-93, the medical centers funded a \$43 million shortfall in the University's operating budget. In 1993-94 and 1994-95, the State redirected \$237 million in SB 855 transfer funds from all transferring entities when they would otherwise have been used to capture federal Medicaid dollars. This redirection of dollars by the state reduced the total amount of SB 855 funds available for distribution. In addition, the University's share of SB 855 funds was reduced by \$15 million on a one-time basis by the Legislature.

The University's plan for accommodating cuts in its 1993-94 State-funded budget included a reduction in health sciences clinical activities, which resulted in both permanent and one-time cuts in CTS for the medical centers.

In 1994-95, the University and the State reached agreement to shift \$18 million of State support from the medical centers on a one-time basis to help meet needs in critically underfunded areas in the general operating budget, (i.e., libraries, instructional equipment, and deferred maintenance). The shift recognized actual and estimated operating gains at the medical centers during 1992-93 and 1993-94, which were above the 5% recommended by the Legislative Analyst, and supported by the Legislature.

In response to this action, the University undertook a study to look at the medical centers' needs for working capital, capital outlay, and equipment, as well as maintaining a prudent reserve. The study concluded that future actions by the Legislature to limit the medical centers' ability to accumulate adequate reserves would make it even more difficult to compete in price-sensitive markets. Notwithstanding this finding, the 1995 State Budget Act redirected \$5.5 million, a portion of the medical centers' net gain above 5%, from CTS funds to help fund the University's deferred maintenance budget on a one-time basis. The medical centers only achieved a 2.8% operation margin in 1995-96, and the \$5.5 million of CTS funds were restored to the medical centers in 1996-97. No cuts in CTS funding have occurred since 1996-97.

## **Funding For Teaching**

Traditionally, funds supporting medical education in a clinical setting have been generated from patient care revenues. A number of significant changes in both the delivery of and payments for patient care have occurred that place these sources at risk. For example, as price becomes a major factor in the medical centers' ability to compete, the centers have accepted negotiated rates that do not recognize the medical education costs. This is occurring at

the same time that patient care revenues are declining. At the same time, the federal Medicare program has reduced the support for reimbursement of indirect costs associated with medical education it provides for graduate medical education. In addition, more care is being provided in ambulatory care centers for which the reimbursement rates do not recognize teaching costs. The following is a brief summary of the major sources of revenue that currently support teaching.

### ***Graduate Medical Education Funds***

Medicare provides teaching hospitals with Graduate Medical Education (GME) payments to help pay for the direct medical costs (DME) of providing a medical education and for the direct programmatic costs allowable under Medicare, such as salary and benefits for full-time-equivalent residents.

Medicare Indirect Medical Education (IME) payments are provided to teaching hospitals for some of the indirect costs associated with medical education, such as the extra demands placed on the medical center staff as a result of the teaching activity or additional tests and procedures that may be ordered by residents.

The combined of DME and IME payments in 2000-01 were \$108.7 million, about 16.5% of Medicare reimbursement to the five medical centers. This is about the same amount that was received in the previous fiscal year. More information about DME and IME funding is provided later in this chapter under *Current Issues – Medicare and Medicaid Budgets*.

### ***Clinical Teaching Support***

State General Funds, called Clinical Teaching Support (CTS), are appropriated to the University in recognition of the need to maintain a sufficiently large and diverse patient population at the medical centers for teaching purposes. These funds are generally used to provide financial support for patients who are essential for the teaching program, but who are unable to pay the full cost of their care.

The 2001-02 budget includes about \$52 million in CTS funds for the five UC medical centers. While CTS funds represent less than 2.2% of the total operating revenue for the medical centers, they continue to be important to the quality of the clinical teaching programs and to the financial stability of the medical centers.

### ***Medi-Cal Medical Education Funds***

In 1996-97, the Legislature adopted supplemental language asking the University to develop options for dealing with the costs of providing medical education in a clinical setting.

The University reviewed many alternatives, and successfully pursued an option to help fund graduate medical education costs through the Medi-Cal program by securing federal matching funds. In 1996-97, the University, working with the California Medical Assistance Commission (CMAC), the Department of Finance (DOF), and the Department of Health Services (DHS), developed a program, specifically for the University's medical centers, that allowed the University to use existing CTS funds to leverage an additional \$50 million in federal Medicaid funds to support educational costs incurred in the treatment of Medi-Cal inpatients.

The State approved legislation (SB 391) to continue the program through 1998-99 and to expand it by creating two supplemental payment funds that are financed through voluntary intergovernmental transfers and then matched with federal Medicaid funds. The supplemental payment funds are the Medi-Cal Medical Education Supplemental Payment Fund, and the Medi-Cal Large Teaching Emphasis Hospital and Children's Hospital Medical Education Supplemental Payment Fund. Medi-Cal contracting hospitals that meet the definition of the university teaching hospitals (e.g., UC medical centers) or major (non-university) teaching hospitals are eligible to negotiate for funding from CMAC to cover the medical education costs associated with Medi-Cal inpatient care.

In 1997, the State approved legislation (SB 1130) which expressed legislative intent that the University take the lead in pursuing a more comprehensive approach to health professionals education funding and report to the Governor and Legislature regarding progress toward a long-term solution. The University submitted to the Governor and the health policy committee of each house of the State Legislature two progress reports, one in December 1998 and the other in March 2000. The University has committed to providing at least one additional report that will propose options for long-term funding of GME. In addition to the reports, the University has worked with the CMAC, the DHS, the DOF, and other stakeholders to develop a proposal for long-term funding of graduate medical and health professions education.

In 1996-97, the University's five medical centers received \$50 million in new federal dollars through this program to help support medical education in a clinical setting. From 1996-97, the inception of this program, to 2000-01 the UC medical centers, received about \$232 million of new federal funds, an average of \$46 million per year. While these funds are critical for the teaching mission of the medical centers, the amount provided is insufficient to fund the actual costs of medical education in an inpatient setting; and no funding is provided to cover costs in an outpatient setting. This program was scheduled to sunset on June 30, 2000. The University worked with the Legislature and the Administration, to secure adoption of a trailer bill to the 2000 State Budget that extended authorization for the program to June 30, 2002.

The University is continuing to work with the State on a broader, longer-term program to fund graduate medical education in both inpatient and outpatient settings, and to include other health care professionals. In April 1999, the University hosted a "Medical Education Financing and Policy Forum" to discuss the current and future financing of graduate medical and related health professions education. This forum provided opportunities for dialogue among leaders and stakeholders of the State agencies, health sciences educational institutions, professional associations, and others in discussing new options and alternative approaches for supporting teaching hospitals and clinics in California. The University created GME task forces comprised of stakeholders to develop a proposed long-term GME funding model for the state. Data are critical for developing options for funding the training of an appropriate health care work force, including non-physician professionals. The University is working with the Office of Statewide Health Planning and Development to develop an assessment of the health care workforce needs of California. The University is also working with the State Legislature to extend the Medi-Cal Medical Education Program beyond the sunset date of June 30, 2002.

## **Other Funds**

### ***Capital Funds for Medi-Cal Disproportionate Share Hospitals (SB 1732)***

The SB 1732 program, the Construction and Renovation Reimbursement Program, provides supplemental Medi-Cal reimbursement to disproportionate share hospitals for debt service costs (i.e., principal and interest) of approved capital construction. Both the Davis and San Diego Medical Centers received approval (Davis in 1998-99 and San Diego in

1999-00) from the DHS for annual supplemental funding of approximately \$7.5 million and \$2.5 million, respectively, over the life of the debt service, assuming the medical center continues to meet all requirements. These funds are for the following projects: The Tower II, the Ambulatory Care Center, Inpatient Radiology Renovations, and the Central Plant at the Davis Medical Center, and Thornton Hospital at the San Diego Medical Center. UC Irvine, also a disproportionate share hospital, had no projects that qualified.

## **Current Issues**

### ***Medicare and Medicaid Budgets***

The 1997 BBA contained some of the most sweeping and significant changes to Medicare and Medicaid since the inception of these programs. These changes were expected to reduce Medicare spending by \$115 billion by 2002. Over the same time, federal Medicaid spending would have been reduced by \$10 billion.

Two of the more significant Medicare cutbacks that affect the University are reductions in the annual inflation adjustments to the Prospective Payment System (PPS) rates for hospitals and in the IME payments for medical education.

The BBA would have reduced the annual PPS adjustment by 1% for each year from 1997 to 2002, thus achieving about \$11 billion in savings over five years. The impact on the UC medical centers was estimated to be about \$45 million during this time. The annual impact was estimated to range from about \$4 million in 1997 to about \$14 million in 2002.

The BBA proposed to reduce the IME factors from 7.7 in 1997 to 5.5 in 2002. This reduction was predicted to achieve \$4.2 billion in savings over five years. Another \$3.4 billion in savings over the same period would have been achieved through changes in DME payments. The impact to the UC medical centers was estimated to be more than \$70 million over the course of the five years. On average, the impact was estimated to range from \$6 million in 1997 to over \$20 million in 2002.

The BBA was expected to cut Medicaid spending by \$10 billion, primarily from reductions in payments for disproportionate share hospitals. These reductions would have greatly affected the UC medical centers because 16% of net operating revenue comes from Medi-Cal. About 27% of all UC medical

center Medi-Cal payments come from disproportionate share payments, (i.e., SB 855 and SB 1255 funds).

A number of groups including UC medical centers and the Association of American Medical Colleges (AAMC) voiced concern that the BBA's significant payment reductions would put teaching hospitals at financial risk. An analysis prepared by the AAMC concluded that the average teaching hospital would lose \$45.8 million in Medicare reimbursement between 1998 and 2002. An analysis prepared by the University of California projected Medicare reimbursement losses of about \$200 million for the five UC medical centers.

Congress responded to the outcries by passing the BBRA in 1999. The BBRA provides temporary relief from the dramatic cuts proposed by the BBA. After the BBRA sunsets September 30, 2002, the cuts imposed by the BBA are slated to resume. The University continued to work vigorously with members of Congress to maintain the momentum established to restore funding or to reduce the impact of future cuts to the Medicare and Medicaid programs. As a result of these efforts and the efforts of other Academic Medical Centers, Congress passed the Benefit Improvement and Protection Act of 2000 (BIPA). The BIPA of 2000 provides temporary relief by delaying for one year the dramatic cuts proposed by the BBA. The BIPA extends temporary relief from the BBA cuts to 2003 and increases the DME funding to 85 percent of the national average.

There are two additional federal actions which are projected to have significant impacts on the UC medical centers: the Health Insurance Portability and Accountability Act (HIPAA) - Privacy Standards and the Medicaid Upper Payment Limits.

The HIPAA privacy standards empower the patient to request, amend and obtain certain information are not unreasonable. However, academic medical centers, given the many arenas in which they interact with protected health information, are more likely than their community hospital counterparts to be the subject of an extensive number of patient requests. The cost to comply with a potentially extraordinary number of requests is an unfunded mandate with significant financial consequences for academic medical centers.

In January 2001, the Health Care Financing Administration (HCFA) finalized the regulation that revised Medicaid's "Upper Payment Limit" rules, ending certain accounting techniques that allow states to inappropriately inflate their share of federal Medicaid matching funds. Though the State of

California did not inappropriately inflate Medicaid matching funds, the new federal regulations may significantly reduce the funding the UC medical centers receive from Medi-Cal supplemental funding programs.

### ***Impacts of Managed Care***

Academic medical centers are profoundly affected by changes in the delivery and financing of health services. These changes are the direct or indirect result of an increase in the percentage of the population enrolling in “managed care plans” for health care coverage. Approximately, 63% of Californians receive their health care through managed care plans, compared to 30% nationwide. When reimbursement was provided on a fee-for-service basis, the medical centers were able to generate the patient volume and dollars needed to support teaching and research. Patients were attracted to the cutting-edge quality of the specialized treatments for complicated health problems offered by academic medical centers.

Managed care seeks to reduce costs in two primary ways. First, managed care emphasizes prevention and primary care intervention in order to reduce the need for more costly hospitalization and specialist services later on. Primary care physicians serve as “gatekeepers,” coordinating care and controlling referrals to more costly specialized services, including inpatient care. Some services that have traditionally been provided on an inpatient basis are now provided in outpatient facilities as efforts are made to reduce costs. Improvements in procedures and new technologies will continue to allow more services to be performed in outpatient settings.

As a result of these trends, the UC medical centers have experienced a shift from inpatient to outpatient settings, a shift that threatens both volume of patients seen in an inpatient setting and reduces revenues.

Consistent with these and other market-driven changes, the University’s clinics show increases in outpatient visits. While there is pressure from accrediting bodies and other policy makers to shift the locus of medical training from inpatient to outpatient care sites, the costs of medical training in outpatient settings are generally higher than in inpatient settings. Further financial challenges have been created by this change, given that medical education costs for outpatient services are not directly reimbursed by Medicare or Medi-Cal. The University is working with the State to identify the costs of medical education in outpatient settings, with the hope that this leads to adjustments in reimbursement by the State and federal governments.

The second way in which managed care seeks to control costs is by contracting with a network of preferred providers to deliver services at negotiated (discounted) rates and to assume risk for a defined population. To compete successfully for these contracts, physicians are joining with hospitals and other providers to form integrated delivery systems that provide the full range of care, from outpatient and lab services to inpatient and skilled nursing care. Integrated delivery systems offer a continuum of care and derive competitive advantages from economies of scale that can result in lower prices; data collection capabilities that can monitor outcomes over time, which can be an advantage in attracting patients; and convenience for insurers, who can negotiate with many doctors and multiple services as a group rather than on a one-on-one basis. Providers who remain outside these networks face a reduced market for their services, as more of the population uses managed health care on either a voluntary or mandatory basis.

As major purchasers of services on behalf of Medi-Cal and Medicare beneficiaries, the State and federal governments are encouraging the development of contractual arrangements with selected providers for these populations. Unless the negotiated rates recognize the legitimate costs incurred by academic medical centers and provide the necessary funding, the University's medical centers will not be able to recover full costs for providing the services.

### ***Seismic Safety Issues***

SB 1953, the Hospital Seismic Safety Act was enacted in late 1994. This legislation requires general acute-care inpatient hospitals to meet standards designed to prevent collapse in a major earthquake by 2008, even though the hospital may not remain operational after the earthquake. By 2030, hospitals would be required to meet higher building standards that would increase the probability of remaining operational following a major earthquake. No provisions for funding were included in the legislation.

Compliance with SB 1953 will affect the State's hospital industry and the delivery of health care, as well as the teaching and research activities conducted at the UC medical centers.

Preliminary estimates suggest that costs to the University's teaching hospitals for compliance with SB 1953 through the year 2008 will be significant, at least \$600 million.

A trailer bill to the 2000 State Budget Act authorized the State Public Works Board (SPWB) to issue up to \$600 million in state lease revenue bonds for seismic work required by the Alfred E. Alquist Hospital Seismic Safety Act (Senate Bill 1953). As with previous SPWB funding for other University projects since the mid-1980s, the SPWB will lease the applicable hospital facility (or a substitute facility under asset transfer) from The Regents and issue lease revenue bonds to finance all or a portion of the costs associated with seismic upgrading required for compliance with SB 1953. The University will build or renovate the project under an agreement with the SPWB. The SPWB retains ownership of the leased facility through the term of the lease or full repayment of the SPWB bonds used for the project, after which ownership is returned to the University.

The University will pay rent to the SPWB for those facilities. This rent will constitute the revenue from which the Board will repay interest and principal on the obligations of the Board issued to refinance the facility. Negotiations between the University and the Department of Finance will determine the repayment arrangements on the debt service.

In anticipation of the sale of the \$600 million of state lease revenue bonds, The Regents approved the following allocations at their meeting in November 2000: Davis - \$120 million, Irvine - \$235 million, Los Angeles - \$180 million, San Diego - \$40 million and San Francisco - \$25 million.

The State's lease revenue bonds will be sufficient to fund the seismic requirements set by SB 1953 through January 1, 2008. In addition, the medical centers have other significant capital needs, such as upgrades necessary for programmatic changes, which cannot be addressed with the State's lease revenue bonds. Therefore, the UC medical centers will be required to use hospital reserves and conduct significant funding campaigns to supplement available funds. The Los Angeles Medical Center has significant funding provided from insurance and from the Federal Emergency Management Agency (FEMA) as a result of damage done by the Northridge earthquake in January 1994.

The 2000 Budget Act also provided \$25 million in one-time funds for medical center equipment and \$50 million capital outlay funds to support urgent infrastructure needs at the medical centers.

The \$25 million appropriation for medical center equipment was provided in recognition of the financial projections which indicate that the medical

centers would not have a sufficient operating margin at the end of 1999-00 to allow for normal capital and equipment costs. The State funds were used for equipment in 2000-01. As a condition for receiving these funds, the Legislature required the University to prepare a report that explained how the funds were used and demonstrated that the funds did not supplement other funds that would have otherwise been used for equipment in 2000-01. Each medical center was allocated \$5 million. The required report was submitted in February 2001.

The 2000 Budget Act also provided \$50 million in State General Funds for infrastructure projects that were non-seismic capital improvements at the medical centers. This funding was appropriated in recognition of the millions of dollars required for improvement apart from the seismic problems to address deficiencies and remain competitive in today's managed care market. Such needs include a broad range of high-priority projects, such as the upgrade of operating rooms, modernization of patient facilities, correction of deficiencies in clinical laboratories, upgrade of deteriorated utility services, and replacement of aged and inadequate building systems. This allocation was made in parallel to the State lease revenue bonds allocation so that the infrastructure work could be done in conjunction with the seismic work. The \$50 million for infrastructure needs were allocated among the medical centers as follows: \$25 million to San Diego, \$10 million to Los Angeles and \$5 million each to the Davis, Irvine and San Francisco Medical Centers.

### ***UCSF Stanford Health Care***

In 1997, The Regents approved the merger of the UCSF Medical Center (Moffitt/Long Hospital and Mount Zion Medical Center) with Stanford Health Services (Stanford Hospital and Clinics, and Lucile Salter Packard Children's Hospital). As a result of the merger, the two medical centers focused on: (1) improving their ability to compete in a managed care environment and to negotiate more favorable provider contracts; (2) sustaining an adequate patient base to support the clinical education mission of the schools of medicine; and (3) consolidating some programs to reduce costs and create efficiencies while maintaining quality. The November 1, 1997 merger created a separate non-profit corporation, UCSF Stanford Health Care, to support the clinical teaching programs of the UCSF School of Medicine and the Stanford School of Medicine.

In its first fiscal year (November 1, 1997 to August 31, 1998, ten months), UCSF Stanford Health Care (USHC) reported a net gain of \$29.5 million. In its second full fiscal year it lost \$78.5 million. The loss was attributable to an

unexpected decline in hospital occupancy, cuts in reimbursements from Medicare and Medi-Cal, rising costs of pharmaceuticals, upgrades to computer systems, increases in staffing, and significant losses at Mount Zion.

In December 1998, management of UCSF Stanford Health hired the Hunter Group, a national health care consulting practice that specializes in turning around financially troubled hospitals. The Hunter Group worked successfully with the UC San Diego Medical Center, which, following a \$20 million loss, has now realized several consecutive successful years.

Given their concern over the financial losses of USHC and the prospect of closing Mount Zion, Bay Area legislators requested an audit of UCSF Stanford Health Care by the State Auditor General. The audit, which was released on August 31, 1999, stated that USHC was unable to achieve the clinical and financial goals of the merger to the degree anticipated. Specifically, the audit noted the failure to combine the intellectual capital of each institution and that the merger costs exceeded savings. In an attempt to reduce losses, the Mount Zion Medical Center closed its inpatient facility in December 1999. Eventually, both Stanford and UC agreed to end the merger, effective March 31, 2000.

### **Responding to the Challenges**

UC medical centers face legitimate concerns regarding the need for adequate funding to support their tripartite mission. In recent years, temporary fixes have provided short-term relief. Significant among these have been the Benefits Improvement and Protection Act of 2000; the extension of Medi-Cal Medical Education program to June 30, 2002, SB 1732 funds for the Davis and San Diego Medical Centers; one-time appropriations in the 2000-01 State Budget for hospital equipment (\$25 million) and for infrastructure (\$50 million); and authorization for the SPWB to issue up to \$600 million of lease-revenue bonds for medical centers to comply with SB 1953, and one-time CTS augmentation of \$5 million in the 2001-02 State Budget.

The medical centers have adapted to the managed care environment by expanding their outpatient and primary care services to complement their existing inpatient services. This has enabled the centers to compete more successfully for commercial contracts, and to provide students with more exposure and training in primary care services. The expanded primary care

patient base has also resulted in more referrals to the University's own inpatient and specialty services.

The University's academic medical centers are also responding by reducing costs through restructuring and improved efficiencies. The centers are developing stronger links with other providers, especially community hospitals and physicians in larger networks.

The following is a brief description of how each of the University's five academic medical centers has or is responding to the changes in the health care industry.

### ***UC Davis Medical Center***

With its exceptionally strong market position and proactive financial management, UC Davis Medical Center has continued to strengthen its teaching, research and public service missions in an ever more challenging health care environment.

With an inpatient occupancy rate pushing 90% and unrelenting demand for its tertiary, emergency and other acute care services, UC Davis Medical Center is striving to maintain its leadership position in the community while responding to the financial realities of the current marketplace.

To meet an unprecedented demand for services, the Medical Center is implementing innovative strategies for managing emergency department patient load, reducing hospital length of stay, expediting admissions and transfers and enhancing operating room capacity. Noteworthy success in recruiting and retaining nurses can be attributed to the medical center's all-RN nursing staff, its acclaimed nursing research program, its status as a "Magnet Hospital". Two new inpatient units under construction in the Tower II will improve access to labor and delivery and certain other high-demand inpatient services.

An integrated management structure that enables the School of Medicine, hospital and physician group to function together as a single entity allows for more focused and efficient responses to market conditions. Strategic contracting, creative cost-reduction initiatives and collaborative approaches to healthcare delivery have enabled the medical center to maintain a relatively stable financial position. With an eye on potential reductions in State and federal funding; substantial seismic upgrade costs and the rising

costs of supplies, labor, and regulatory compliance, medical center leaders are taking a proactive approach to strategic and financial planning.

UC Davis Medical Center continues to forge collaborative relationships throughout the region, strengthening its position as a referral center and building its reputation as a public service provider and “good citizen”. Collaborations with community hospitals from Merced to Redding are bringing cancer care, pediatric intensive care and other tertiary services to rural regions of northern California. Collaborations with scientists at Lawrence Livermore National Laboratory boost UC Davis Medical Center’s strengths in basic science research and help position the cancer center in its bid for National Cancer Institute designation. Strong ties to local community organizations and agencies – from schools to social service providers – reinforce UC Davis Medical Center’s position as a leader in the Sacramento region.

### ***UC Irvine Medical Center***

UC Irvine Medical Center has just completed the most successful year in its 25-year history, for the fiscal year ending June 30, 2001.

UCIMC recorded its sixth consecutive year of operational gains. This success was achieved by continued growth in outpatient and inpatient referral business, tight control of expenses, and substantial growth in patient care revenues. In addition, the Medical Center achieved an outstanding score of 96 on its Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accreditation survey, the faculty physician group was named as one of the finest in California and the hospital was named one of the nation’s top hospitals in the field of gynecology by U.S. News and World Report.

Planning for a new hospital will continue to be the major focus in the coming months. The growing demand for UCIMC’s specialty services coupled with Orange County’s growth rate and aging population necessitates that a facility be built that will be large enough to serve the academic and patient care missions while meeting the needs of the community. Adding to the capital needs of UCIMC are the costs of advances in diagnostic and treatment technology and new compliance information systems required by the federal HIPAA standards. Advances in the electronic medical record, physician order entry, and systems to minimize risk of medical errors are also sorely needed.

In order to meet the significant capital needs of the next five to ten years, UCI Medical Center is developing plans for a strategy that will provide it

with the capital needed to maintain momentum and continue the transformation of UCIMC into one of the regions most successful hospitals.

Now in the fourth year of our Health Sciences Strategic Plan, the Medical Center and College of Medicine continue to meet or exceed all research, educational, and clinical enterprise goals. The success of the plan can be attributed to an institution-wide focus on quality, customer satisfaction, and financial performance, as well as a renewed commitment to the highest ethical standards in the conduct of research and patient care.

However, UCIMC faces a number of formidable challenges as it enters fiscal year 2001-02. Like other markets in California, Orange County continues to be a very difficult environment for physicians and hospitals. There have been a number of well-publicized medical group bankruptcies over the last several years and there continues to be significant uncertainty throughout the physician community. Pressure on the remaining physician groups from managed-care forces is putting additional financial stress, leading many of them to take a tough approach to contract renewal negotiations with UCIMC. Since the Medical Center increasingly serves as a tertiary care referral center for many of these regional medical groups, their financial health will continue to be a concern. The Medical Center is looking for any signs of financial distress among these referral sources so that it will be prepared to mitigate the negative impact of any additional bankruptcies.

Financial weakness among the large payors like Pacificare is also a concern. Although the Medical Center has now eliminated capitated contracts, except for Cal-OPTIMA (managed Medi-Cal), Health Net, and Aetna. UC employees, it is concerned about the impact of health plan financial problems on its referral network. The Medical Center has been successful with rate negotiations with some insurance plans, while other negotiations are slow and contentious.

The Medical Center is also currently in negotiations with Orange County Health Care Agency for several services UCI has historically provided the Orange County residents. The Medical Center hopes to establish a long-term partnership with the County of Orange for the care of county-responsible patients.

The rising costs of providing patient care is also a major concern. Shortages of nurses and other health professionals are contributing to significant wage inflation and increasing the use of registry staff at higher hourly rates. The

Medical Center is beginning to experience shortages of anesthesiologists and radiologists and must raise the salaries of these hospital-based physicians to continue to provide these hospital services for its patients. In addition, double-digit increases in pharmaceutical costs are worrisome. Some of the recent biotechnology treatment marvels are costing thousands of dollars per dose and are not being appropriately reimbursed by governmental or third party insurers. The Medical Center is currently negotiating with Medi-Cal and Cal-OPTIMA to secure carve-outs for the most expensive new drugs, it is unclear if such an agreement can be reached.

### ***UCLA Medical Center***

The UCLA Medical Center continues to remain viable in a very difficult and competitive southern California environment. This market is experiencing further payor consolidation with financial failure of marginal health plans (e.g., Maxicare, Watts Health Foundation), resulting in increased leverage among the remaining health plans.

During the past fiscal year, there has been a continuing trend of financially distressed Independent Practice Associations (IPA) and medical groups closing or filing Chapter 11 bankruptcy (e.g., Chaudhuri Medical Group, Health Source, Family Health Care Medical Group and Little Company of Mary Health Service's Medical Institute). This trend increases the risk of underpayment and/or no payment for hospital services rendered to patients of failing IPA's and medical groups.

With respect to the local hospital industry, both independent and some health system non-profit hospital providers are barely breaking-even or experiencing financial losses. On the other hand, for-profit hospital systems, which have met or exceeded Wall Street's expectations, are selectively acquiring failing non-profit hospitals (e.g., Daniel Freeman Hospitals, Inc.), expanding clinical program capabilities and physical plants, and in one instance, planning to build a brand new hospital (Palmdale, California). While not an immediate threat, the questionable long-term financial stability of the Los Angeles County health system and implications for UCLA Medical Center will need to be evaluated.

On the state level, "deconsolidation" of one of the major non-profit statewide hospital systems is occurring, as the previous Daughters of Charity (DoC) hospitals (three in Los Angeles) are in the process of separating from Catholic Healthcare West (CHW), the largest non-profit hospital system in the state. The Medical Center will need to watch the impact of this separation, since it

has clinical program relationships with selected CHW hospitals. The energy crisis that has absorbed much of the State's attention during the past year has and may continue to increase the energy costs of the Medical Center. Mandated salary increases have also negatively impacted the Medical Center's expenses. Looking forward, passage of legislation requiring high nurse-to-bed staffing ratios has the potential to add to the cost of care at the Medical Center.

On the federal level, the Medical Center may be burdened with additional costs associated with implementing the requirements of the 1996 HIPAA. Another potential future financial challenge to the Medical Center's bottom line will be the Centers for Medicare and Medicaid Services (CMS), formerly HCFA, proposed ruling to reduce outpatient pass-through payments.

Despite its challenging environment, UCLA Medical Center continues to be successful as management implements the recommendations from the "1997 Medical Enterprise's Primary Care Network" and leveraging the capabilities and resources of Santa Monica – UCLAMC, the Medical Center has strengthened its primary service area position. UCLA's regional strategy has also been effective in maintaining and increasing specialty referrals from outside its immediate service area.

The fruits of these endeavors are reflected by the Medical Center's increased utilization. As of fiscal year-to-date August 24, 2001, the Medical Center is operating at an average daily census (ADC) of 470, compared with ADC of 451 during the same time period last year. Since July 1, 2001, the Medical Center's ADC has risen above 500 on ten separate occasions.

During the upcoming 2002-2003 fiscal year, UCLA Medical Center's major financial objectives will be to: 1) improve its financial operating performance; and 2) increase cash reserves. With respect to the former, management will focus its efforts to reduce out-of-network costs and other significant controllable costs (e.g., pharmaceuticals), increase work productivity, and leverage Santa Monica-UCLAMC to match patient acuity with an appropriate level of acute cost of care.

To enhance the Medical Center's cash position, management will continue to prioritize timely accounts receivable collections throughout the organization, limit the organization's capital expenditures, effectively manage the costs of the hospital replacement building programs, and reduce the level of transfers

for support to the School of Medicine from the medical center to an as needed basis.

With successful implementation of these actions, UCLA Medical Center should continue to serve as an important and prestigious academic, research, and clinical resource for the residents of California.

### ***UC San Diego Medical Center***

The UC San Diego Medical Center continues to remain financially sound with a strong cash position and profitable operations for the fifth straight year in a row (i.e., 1996-97 through 2000-01). This profitability is attributable to efforts to secure disproportionate share funding, manage costs in a period of labor shortages and significant increases in medical supply and utility costs, and successfully access the capital markets to reduce debt service.

For fiscal year 2000-01, the Medical Center reported a net profit of \$36.7 million. Revenues grew 7% over last fiscal year as a result of increased patient activity and improved contract performance. Inpatient admissions increased by 4% over last fiscal year due in part to the success of the Medical Center's two-site strategy. Patient admissions increased at both the Hillcrest and La Jolla facilities. Expenses also grew related to several factors: the nursing shortage, recently negotiated wage increases resulted in a significant increase in labor costs, inflationary increases to pharmaceuticals and medical supplies were significant, and natural gas costs tripled.

Challenges faced by the Medical Center include the regulatory changes being proposed which could significantly reduce the amount of disproportionate share and medical education support available in the future, the continued tight San Diego labor market, additional increases in utility costs as fixed-rate contracts for electricity expire and accumulating capital resources needed to meet seismic and infrastructure requirements of the primary teaching facility in Hillcrest.

To meet these challenges, the UCSD Medical Center's strategic plan focuses on the following initiatives: 1) enhance centers of excellence to retain and attract patients; 2) focus on core operations through partnerships with physicians to manage operations and control cost; and 3) enhance revenues. As part of the strategy to enhance revenues, the Medical Center is evaluating its relationships with managed care payors.

## ***UC San Francisco Medical Center***

The San Francisco Medical Center, maintains an outstanding national reputation, ranking 9<sup>th</sup> in the US News and World Report Survey.

Patient activity at the Medical Center continues to be very strong, built largely on referrals of patients from physicians throughout Central and Northern California. Inpatient occupancy exceeds 80%, and the acuity of the patients seen is among the highest in the University of California system. Outpatient activity continues to grow at the robust rate with over 600,000 visits a year.

UCSF Medical Center's programs in areas ranging from Woman's Health through neurosurgery and organ transplantation continue to be national models. The first clinical building of the only Comprehensive Cancer Center in Northern California was opened October 2000, and is now seeing patients at the rate of 50,000 visits per year. The Medical Center's leading children's health programs, far larger than those at competing regional children's hospitals, are growing and is appropriately recognized as a University Children's Hospital.

UCSF Medical Center's themes for fiscal year 2000-01 were to improve operational efficiency and achieve financial stability, following the dissolution of the merger with Stanford Health Services. Management was strengthened, with the retention of a permanent Chief Financial Officer and Chief Information Officer, and the conclusion of the Hunter Group hospital management contract in March 2001. Staffing was stabilized and steps were taken to improve morale, including the initiation of a hospital-wide employee incentive program. The hospital prepared for and successfully completed its tri-annual Joint Commission on Accreditation of Healthcare Organizations (JCAHO) Survey and received a three year accreditation. Inpatient capacity continues to be an important issue for UCSF Medical Center. During 2000-01, the Medical Center completed renovation of the 11<sup>th</sup> floor critical care unit, which increased critical care capacity by 16 beds, Mount Zion Hospital was reopened for short-stay surgery, and projects to renovate and expand the Moffitt Operating Rooms and Emergency Department were initiated.

Financial performance in 2000-01 reflects the beginning of the post-merger financial turn-around at UCSF Medical Center. The net loss in fiscal year 2000-01 of \$16.8 million (i.e., the Medical Center reported an \$8 million loss and Physician Services reported an \$8.8 million loss) was better than the

\$25.0 million loss projected in the budget and far less than the \$59.6 million annual rate of loss experienced in the final quarter of 1999-2000. There was \$54 million in cash reserves at the beginning of 2000-01 but the cash reserves dropped to \$22 million by December 2000. By the end of the fiscal year cash reserves increased to \$36 million.

UCSF Medical Center's focus for 2001-02 will be to utilize the stable operational and financial base to rebuild strong operating fundamentals. The goals of the Medical Center are:

- to improve the quality of care, as measured by the standards used by the JCAHO.
- to improve patient satisfaction, as measured through patient surveys.
- to reduce losses to \$10 million or less by year-end.

Efforts to achieve these goals will include the following major projects:

- Improvement of controls over operating and capital disbursements.
- Better utilization of inpatient capacity – particularly during the busy winter months.
- Continuation of major construction projects to expand or enhance the Operating Rooms, the Emergency Department and the seismic safety of the facilities.
- Re-design of “the front-end” (i.e., registration, financial evaluation, cashiering, etc.) of ambulatory care to increase patient and physician satisfaction, as well as, increase professional fees and hospital ancillary services collection rates.
- Simplification and clarification of the clinical income funds flow between the Medical Center and Medical Group.

Finally, UCSF Medical Center, working with the faculty, will complete a strategic plan for the Medical Center and the clinical practices that will cover the next three to five years. The plan will contain the operational and financial blueprint for how the clinical enterprise will develop, expand and rebuild its facilities to meet the needs of out-patients and faculty.

## **Future Issues**

As UC medical schools and medical centers look to the future, the University remains committed to excellence in health sciences education and responsiveness to societal health needs. Meeting these challenges successfully will require increasing collaboration among educators, teaching hospitals, managed care organizations, and others to ensure that the quality of patient care and medical education continue to meet the high standards of American medicine and modern society.

With their tripartite mission of teaching, public service, and research, UC's academic medical centers constitute a major resource for California and the nation by providing excellent training for tomorrow's health professionals, educational opportunities for community health professionals who participate in the University's clinical teaching and continuing education programs, and health care services to thousands of patients each day.

Below is a partial list of issues that the UC medical centers are addressing:

- Compliance with SB 1953.
- Increasing energy costs.
- Increasing salary costs, especially for represented employees.
- Sunset of the Medi-Cal Medical Education Program on June 30, 2002.
- The costs of compliance with HIPAA.
- Medicare and Medicaid cuts in reimbursement after BIPA legislation sunsets in 2003.
- The financial impact of the Upper Payment Limits.
- Sustainable support for the Schools of Medicine.