California State Auditor

BUREAU OF STATE AUDITS

UCSF Stanford Health Care:

The New Entity Has Not Yet Produced Anticipated Benefits and Faces Significant Challenges

August 1999
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CALIFORNIA STATE AUDITOR

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August 31, 1999 99128

The Governor of California
President pro Tempore of the Senate
Speaker of the Assembly
State Capitol
Sacramento, California 95814

Dear Governor and Legislative Leaders:

As requested by the Joint Legislative Audit Committee, the Bureau of State Audits presents its audit report concerning a review of the operational changes that have occurred as a result of the merger of the University of California, San Francisco Medical Center and Stanford Health Services. Additionally, we were asked to review the factors that may have caused the hospitals to lose money and to determine the cause of the UCSF Stanford Health Care's (USHC) failure to achieve the expected benefits of the merger. Lastly, we reviewed the actions planned to achieve operational savings goals and whether the USHC's recovery plan is likely to be achieved.

This report concludes that USHC has been unable to achieve the clinical and financial goals of the merger to the degree anticipated. Specifically, USHC has failed to combine intellectual capital, and incurred actual merger costs that exceeded savings from merging.

Further, we estimate the merger contributed $19 million in losses during the first two years, but it may generate $140 million in profits in the next two years if the portions of proposed revenue enhancements and cost savings that we attribute to merger-related activities are achieved.

Respectfully submitted,

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SUMMARY

Audit Highlights . . .

Our review of the merger between UCSF and Stanford revealed:

- ☑ *USHC has been unable to combine its intellectual capital and integrate clinical programs to the degree anticipated.*
- ☑ *Estimated losses may reach $46 million for its first two years of operation rather than the anticipated gain of $65 million.*
- ☑ *Deteriorating reimbursement rates, insufficient cost savings, sharply rising costs, and more than double expected merger costs significantly contributed to its financial woes.*
- ☑ *Consultants believe cost reductions of $170 million annually are essential, but taken alone will not bring profitability.*

RESULTS IN BRIEF

In 1997, the University of California, San Francisco Medical Center (UCSF) and Stanford Health Services (Stanford) merged to create a stronger entity better positioned to face future health care challenges than each would have been separately. The success of the merger was premised, in major part, on two important goals:

- Generating an additional revenue stream of about $50 million annually by combining the intellectual capital of the two prestigious medical institutions, thus creating a "world class" organization that would significantly increase its market share of highly specialized, and potentially lucrative, cases.
- Lowering costs by about $30 million annually through consolidating duplicate services.

In the 22 months since merging, UCSF Stanford Health Care (USHC) has been unable to achieve these goals to the degree anticipated. First, the two entities have not combined their intellectual capital as planned since they have not fully integrated clinical programs. Also, USHC now estimates a loss of $46 million for its first two years of operation rather than a financial gain of $65 million as projected in the business plan—a difference of $111 million. Moreover, the overall case complexity level has remained about the same after the merger due, in part, to USHC's change in approach that focuses on increasing total revenue regardless of the type of case.

To address its deteriorating financial condition, USHC employed one of its consultants to create a financial recovery plan. To bring USHC expenses in line with those of other academic medical centers, the consultant identified cost savings targeted to total $170 million annually by August 2001. In addition, the consultant developed an inventory of other revenue and expense opportunities totaling an approximate $100 million annually for USHC to consider. These latter opportunities may not be fully achieved due to various political, managerial, community, and other concerns.

If it successfully implements the consultants' recommendations or identifies other opportunities totaling $270 million annually by the end of August 2001, the consultants estimate that USHC will show a modest $47 million profit in fiscal year 2000-01. These recommendations include many savings UCSF and Stanford would have needed to consider had they not merged and others that are dependent upon consolidating administrative functions only possible because they merged.

To estimate the approximate financial effects from merging, we allocated revenues and expenses between activities we considered related to the merger and those that would have existed without the merger. We estimate the merger contributed $19 million in losses during the first two years, but it may generate $140 million in profits in the next two years if portions of the $270 million in revenue enhancements and cost savings that we allocated to the merger are achieved.

Cost reductions will be necessary whether the entities remain together or separate. However, if the two institutions are not both strengthened by their affiliation to the degree that was initially envisioned, the justification for continuing the relationship may be called into question. Currently, UCSF and Stanford are considering whether to continue the present form of governance. They will need to determine if their objective is still to enhance their academic missions by combining intellectual capital or if they are only interested in reducing administrative costs. In addition, they will need to find a corporate structure that will allow them to maximize their return on the significant investment USHC has made in infrastructure for the consolidated functions of accounting, computer systems, marketing, and others.

Regardless of its current financial difficulties, key indicators appear to suggest that USHC has maintained its commitment to patient access to quality health care and increased its support of community programs.

AGENCY COMMENTS

The UCSF Stanford Health Care generally agreed with our conclusions. ■

INTRODUCTION

BACKGROUND

When it merged with Stanford Health Services (Stanford) to form UCSF Stanford Health Care (USHC) on November 1, 1997, the University of California, San Francisco Medical Center (UCSF) believed that this merger would enhance its academic mission, strengthen its regional referral role, and create a more cost-effective teaching hospital. This would allow both UCSF and Stanford to maintain financial support for their academic missions while reserving funds for the ongoing program requirements and initiatives of the hospitals. Further, UCSF believed the merger would sustain an adequate patient base for education and create opportunities for clinical research and collaborations between the two faculties and medical staff.

Prior to the Merger

Prior to the merger, UCSF used its medical center as the primary research, teaching, and learning vehicle for its students, faculty, and staff. The medical center was composed of three hospitals: UCSF/Mount Zion Hospital (Mount Zion), Moffitt-Long Hospital, and Langley Porter Psychiatric Hospital and Clinic. The Langley Porter Psychiatric Hospital and Clinic was not included in the merger. In 1997, the remaining two hospitals were staffed by approximately 900 physicians and provided nearly 900 licensed beds with an average of 160,000 days of hospital care annually.

In comparison, Stanford was a university-owned nonprofit corporation that included Stanford University Hospital, various Stanford University clinics, and the Lucile Salter Packard Children's Hospital. At the time, these facilities had a medical staff of 1,800 physicians and provided 814 licensed beds with an average of 164,000 days of hospital care annually. Further, Stanford had more than 100 outpatient clinics where medical school faculty focused on treating patients and training doctors.

The Formation of UCSF Stanford Health Care

To unite Stanford Health Services with UCSF Medical Center,the University of California Board of Regents voted on November 15, 1996, to create USHC, a nonprofit, public-benefit corporation. Prior to this decision, a series of reports were produced that explored the feasibility of the merger and analyzed the business environment and health care market. The two primary reports were prepared by Ernst & Young, LLP, and by Warren Hellman with the assistance of Bain & Company. Ernst & Young, a consulting firm, prepared a business analysis of the merger, assessing the long- and short-term benefits and examining the potential risks involved for both UCSF and Stanford. Warren Hellman conducted an independent review (Third-Party Review) that focused on whether the merger was a sound business decision for UCSF and if the analysis to date was sufficient. Although these parties generated different reports, the conclusions were similar in that each suggested UCSF and Stanford should proceed with the merger.

In 1997, we reviewed the proposed merger and discussed in our report the changes in the health care market that supported the merger strategy, the financial comparability of the two entities, and the potential overstatement of estimated financial benefits from the merger. In addition, we presented UCSF's rationale for the merger, UCSF's and Stanford's planned contributions to their medical schools,[1] and an analysis of past financial performance of the two entities in relation to others in the medical industry. For more detail on our prior audit issued in September 1997, please refer to Report #97122 titled *The UCSF and Stanford Health Services: The Proposed Merger Should Make the Partners Fiscally Stronger, Although the Extent of Financial Benefits Is Potentially Overstated*.

Purpose of UCSF Stanford Health Care

The primary purpose of the new entity was to support, benefit, and further the charitable, scientific, and educational purposes of the UCSF and Stanford schools of medicine. Specifically, it planned to provide support by transferring funds in exchange for the faculties' clinical activities; to maintain educational venues for physician training; and to reinvest earnings from its clinical activities into UCSF and Stanford academic activities such as education, research, and discovery. Further, USHC feels its ultimate role is "to serve San Francisco and Northern California

[1] UCSF's and Stanford's medical schools were not included as part of the merger.

by providing a comprehensive range of acute care services to adults and children, focused on those services others cannot provide."

Although UCSF and Stanford agreed to transfer equipment, personal property, and other assets to the merged entity at no cost, both separately retained title to all land, buildings, and improvements in their respective medical centers. Upon completion of the merger, control of the assets and operation of UCSF Medical Center and Stanford Health Services transferred to a 17-member governing board of directors. However, its merger agreement stipulated that should either UCSF or Stanford determine that USHC fails to carry out the purposes for which it was organized, either entity may petition for an involuntary dissolution.

USHC is now a private, nonprofit organization, operating four acute-care hospitals: Moffitt-Long Hospital, Mount Zion Hospital, Stanford University Hospital and clinics, and Lucile Salter Packard Children's Hospital. The organization currently operates the medical practices of about 2,000 full-time faculty physicians with 12,000 employees, including 3,800 registered nurses. It provides approximately 350,000 days of hospital care annually and performs services with an annual operating budget of $1.5 billion.

SCOPE AND METHODOLOGY

The Joint Legislative Audit Committee requested the Bureau of State Audits to perform a review of the operational changes that have occurred as a result of the merger of UCSF and Stanford. Specifically, we were asked to review the factors that may be causing the merged entity to lose money and determine the cause of USHC's failure to meet expected benefits of the merger. Further, we were to review the actions USHC has planned to achieve operational savings goals and whether its recovery plan is likely to be achieved.

To assist us in evaluating the merger and its resulting impact, we hired a health care economics and strategy-consulting firm, Analysis Group/Economics. Analysis Group performed a review of the changes in the health care market in the two years since the merger in November 1997 and searched for reasons why USHC failed to attain expected financial benefits. Our

consultant also calculated trends from financial and operational data submitted by USHC to the Office of Statewide Health Planning and Development (OSHPD) and used these trends to compare USHC's operating results after the merger with those of UCSF and Stanford before the merger.

To determine whether USHC realized the clinical and financial benefits expected from the merger, we jointly reviewed summary financial data and interviewed hospital administrative and medical staff. Specifically, we compared anticipated results from the pre-merger business plan with actual clinical and financial results from summary financial and management data. Further, we identified the causes of any differences.

Our health care experts also determined if the anticipated revenues and cost savings to be generated by the newly proposed recovery plan and inventory of opportunities are reasonable and based on appropriate assumptions, and whether the plans provide sufficient detail to ensure that the changes actually can and will take place.

To determine the effect of the merger on access to quality health care, we reviewed the results of patient surveys and statewide data compiled by OSHPD. To determine any significant change in the amounts spent on charity programs, we reviewed audited financial statements and community benefit reports and compared amounts spent by the hospitals before and after the merger. We also analyzed hospital data compiled by the OSHPD to identify changes in the number of indigent patients served by the hospitals before and after the merger. ■

CHAPTER 1

UCSF Stanford Health Care Has Not Met Its Short-Term Medical, Academic, and Financial Expectations

CHAPTER SUMMARY

The University of California, San Francisco Medical Center (UCSF) and Stanford Health Services (Stanford) merged to form UCSF Stanford Health Care (USHC) in 1997 to remain competitive in the Bay Area[1] health care market. Individually, each had faced mounting financial pressures, and expected to save money by consolidating certain functions and achieving economies of scale. For the most part, however, the success of the merger was predicated on USHC's ability to capitalize upon the combined and enhanced reputation of the two entities to increase its volume of highly specialized cases drawn from the Bay Area and beyond.

Thus far, USHC has largely failed to realize its aspirations and now estimates a loss of $46 million for its first two years of operation. Factors contributing to USHC's lack of success include deteriorating reimbursement rates, overhead and corporate infrastructure cost savings insufficient to offset sharply rising costs in other areas, inadequate information systems for performance monitoring, and greater merger costs than anticipated. Using USHC's fiscal year 1997-98 audited financial statements and fiscal information for 1999, we estimated what financial results the two separate entities could have produced had they not merged. Based on that analysis, UCSF and Stanford would have incurred a $27 million loss in the last two years had they not merged.

USHC's failure to achieve its objectives results fundamentally from its failure to fully integrate its two faculty medical staffs and consolidate clinical programs. Adoption of system-wide best practices has progressed slowly, and thus has limited USHC's ability to fully benefit from a combined reputation as a health care provider superior to the pre-merged entities. However,

[1] As used throughout this report, except as otherwise noted, the Bay Area consists of the following 10 counties: Alameda, Contra Costa, Marin, Napa, San Francisco, San Mateo, Santa Clara, Santa Cruz, Solano, and Sonoma.

USHC has demonstrated some ability to attract more highly specialized cases. Specifically, the volume of highly specialized cases has increased at nearly the rate forecast in the merger plan. Other less complex cases generally not attributable to the merger have grown at even higher rates; however, this increase alone is not sufficient to counteract the effects of lower reimbursement levels and higher than anticipated costs.

THE MERGER HAS NOT PROMOTED THE ACHIEVEMENT OF USHC'S MEDICAL AND ACADEMIC MISSIONS IN THE MANNER ANTICIPATED

Because they are teaching hospitals, UCSF and Stanford have higher costs than competing facilities.

The merger was primarily a response to ongoing changes in the Bay Area's health care services market. Managed care plans, including health maintenance organizations (HMOs) that offer a comprehensive set of health services, attempt to control spending by closely managing the use of physician and hospital services and by using their bargaining power to lower payments to health care providers. The expansion of managed care has resulted in a decline in the number of inpatient admissions, producing an oversupply of hospital beds and growing financial pressure on hospitals in the Bay Area. The pressure at UCSF and Stanford was particularly intense since these hospitals have higher costs than competing facilities, at least in part, due to their missions of medical education and research.

USHC's Inability to Integrate Faculty May Lead to Merger Failure

One of the greatest disappointments of the merger may be USHC's failure to achieve the level of integration and cooperation between the two medical schools anticipated at the outset. Without such integration, the likelihood of achieving the long-term academic and financial benefits of the merger is greatly reduced.

The pre-merger business plan anticipated that the merger of the medical facilities and integration of faculty and medical staff would advance clinical research by increasing the number of patients, improve clinical outcomes,[2] and reduce costs by promoting the adoption of clinical best practices. More importantly,

[2] According to the director of the Quality Improvement Division, clinical outcomes are assessments that gauge the effect or results of treatment for a particular disease or condition. Outcome measures include the patient's perception of restoration of functional status, as well as measures of mortality, morbidity, cost, quality of life, patient satisfaction, and others.

this integration would allow USHC to attract more highly specialized cases, increase revenue, and continue support of its academic mission. The merger business plan called for USHC to generate 1,500 additional highly specialized cases annually to expand overall patient population and provide more exposure to primary care teaching sites needed to train medical students. The expanded patient population would also set the stage for creating new training programs that the individual hospitals did not have the critical mass to support and for expanding opportunities for in-house staff rotations.

Based on interviews our health care experts conducted, several factors may have contributed to USHC's failure to integrate faculty. One major factor is that the primary allegiance of the faculties is to their respective medical schools and not to USHC. Further, the medical faculties have strong incentives to gain personal recognition for their innovations and may be reluctant to collaborate. In addition, differences in administration and methods of faculty appointment and compensation at the two campuses may have further contributed to USHC's failure to fully integrate. Our interviews suggest that deterioration in UCSF's financial performance may have caused Stanford faculty to feel that their efforts were subsidizing UCSF. Discussions surrounding the current financial problems and possible reduction in future financial support of the medical schools have only increased tension.

Instead of fostering system-wide programs, 13 of 16 service lines, intended to encourage faculty cooperation, were eliminated.

Failure to fully integrate the medical services may be the most significant impediment to the long-term success of the merger. In essence, USHC has failed to establish fully consolidated clinical programs. Instead of fostering the development of system-wide programs, it eliminated 13 of 16 service lines [3]—intended to encourage cooperation among faculty. Further, the lack of faculty integration has led to USHC's failure to consolidate small clinical programs and achieve the resulting savings. Moreover, except for children's services, UCSF and Stanford medical faculties have established separate work groups to identify opportunities for supply savings rather than work together to identify larger savings, an important aspect of the consultants' recovery plan that we discuss in Chapter 2.

[3] A service line is a group of related hospital and physician services that are organized and promoted as a single integrated service offering. Examples include adult cardiac service and pediatric neuroscience.

Although the level of integration has been disappointing overall, we did find some noteworthy areas of success. For example, the faculties have been effective in cooperating and have cited progress towards developing system-wide programs in adult cardiac care and children's services. Even as the efforts of each campus to identify cost savings are mostly expended in separate work groups, some cross-campus discussions have produced savings. In particular, both medical faculties worked together to standardize the use of cancer drugs and protocols and certain supplies, such as cardiac catheters and stints. In addition, USHC reports that it has made some progress recently toward establishing a combined drug formulary. Despite these successes, without fuller integration of faculty, shared medical knowledge, and consolidation of programs, USHC is unlikely to realize the full benefits anticipated at the outset of the merger.

USHC HAS NOT PRODUCED THE EXPECTED FINANCIAL PROFITS

Currently, USHC is not on track to meet the full benefits of the merger as detailed in the original business plan. It now estimates a loss of $46 million for its first two years of operation rather than a financial gain of $65 million as projected in the business plan, a difference of $111 million. As we will discuss throughout this chapter, many factors have contributed to USHC's deteriorating financial condition. The merged entity itself was responsible for some of the factors. For example, its merger costs are more than double its original estimates. However, USHC had no control over other factors such as deteriorating reimbursement rates in the health care market and unexpected increases in the cost of pharmaceuticals and medical supplies. In addition, historically low unemployment has made it more difficult for USHC to hire and retain employees. These factors would have existed and affected UCSF and Stanford even if the entities had not merged.

While merger costs, which are more than double estimates, are within USHC's control, other factors such as deteriorating reimbursement rates and drug and medical supply costs are not.

To determine the effect of these factors on the financial results that UCSF and Stanford could have produced had they not merged, we performed an analysis to identify the revenues, expenses, and ultimate profit or loss not attributable to merged activities. Based on our analysis, we estimate that the two entities would have realized a loss of only $27 million had they not merged rather than $46 million currently expected from merged operations. Our calculations and complete analysis are presented in Appendix A. Although the merger has not helped the financial

position of UCSF and Stanford over the last 22 months, given more time, USHC may realize the anticipated merger benefits in the future. We discuss USHC's prospects for future profitability in Chapter 2.

Prior to the Merger, Substantial Financial Advantages Were Expected

Even in the months preceding the merger, estimates of financial benefits began to decline.

Originally, UCSF and Stanford expected the merger to provide opportunities that would increase revenues and reduce costs by enhancing reputation, eliminating competition with a main rival, consolidating administrative functions, and achieving economies of scale. However, even in the months preceding the merger, estimates of the financial benefits began to gradually decline. In May 1996, Ernst & Young first identified $254 million in additional profits over four years of merged operations from 1997 through 2000. In October of that same year, Warren Hellman concluded in his Third-Party Review that the additional revenue included in the Ernst & Young report was too generous and reduced projections by 50 percent to $152 million. Finally, in August 1997, Ernst & Young revised its earlier estimates and anticipated the merger would achieve just under $120 million in additional profits over four years.

In our prior report, we also estimated the merger could achieve benefits close to $120 million in the first four years if the business plan was implemented. The sensitivity analysis[4] detailed in our prior report indicated that if USHC did not succeed in increasing its specialized case volume above pre-merger levels, it would have to achieve 84 percent of its projected cost reductions for the merger just to break even over its first four years of operation.

USHC Realized Additional Revenue From Highly Specialized Cases

A key element of the merger strategy was the assumption that UCSF and Stanford combined could significantly increase the number and proportion of highly specialized cases over what the hospitals could achieve if they remained separate. The theory was that USHC could realize significant profits from the increase in these cases. From a pre-merger base of approximately 16,700, the number of highly specialized cases was expected to

[4] A sensitivity analysis was performed to analyze the estimates of financial benefits from the merger assuming various percentages of the projected additional revenues and cost savings were achieved.

increase by 750 (4.5 percent) in the first year of operation and 1,500 (9 percent) in subsequent years, to a total of approximately 18,200 cases per year. Although the pre-merger business plan prepared by Ernst & Young contained estimates of additional specialized cases per year, it did not forecast any increase in the number of less complex cases. Presumably, Ernst & Young had no reason to believe the merged entity would be a more effective competitor for these less complex cases than were the pre-merger entities operating separately.

At the time of the merger, detailed marketing plans to attract these new cases had not yet been prepared to avoid sharing sensitive competitive information between UCSF and Stanford. However, several broad strategies were being considered. First, price reductions of 3 percent to 7 percent were incorporated in the forecast. Second, USHC planned to document improved, cost-effective outcomes that were expected to result from their adoption of best practices and collaboration among faculty and staff. Third, a concerted effort to strengthen referral relationships between USHC and community hospitals, medical groups, and regional health plans was anticipated. Fourth, by combining to form the only academic medical center in the Bay Area, it was believed insurers would find it necessary to contract with USHC to attract enrollees. Finally, it was believed that the merged entity could position itself as the best provider of high-quality, highly specialized care in the Bay Area and successfully promote the USHC brand name. At the time of the merger, it was unclear which of these strategies USHC would ultimately adopt.

A key strategy for increased revenues was premised on growth in the first year of 4.5 percent and 9 percent in the second year of specialized cases.

In our prior report, we agreed that the strategies were sound if implemented but that only a portion of the increased patient population could be related to the merger. Specifically, we stated the following:

> *Although these strategies may be more effective when implemented by the merged entity, each strategy can be implemented regardless of whether a merger takes place. Consequently, only a portion of the patient volume expected to result from these strategies should be attributed to the merger itself. For instance, UCSF on its own could document and market its high-quality care and could also approach community hospitals about redirecting their patients needing highly-specialized care.*

USHC could not provide us a comprehensive enterprise-wide marketing plan of the caliber expected from a $1.5 billion company attempting to establish a new identity in a highly competitive market.

After the merger, USHC has undertaken marketing initiatives consistent with some of the strategies contemplated in the merger plan. Specifically, it has made efforts to enhance referral relationships with medical groups and hospitals throughout Northern California. Further, it has attempted to position itself as the premier provider of high-quality, highly specialized care in the Bay Area, and has promoted the USHC brand name through advertising and other means. Two strategies proposed in the merger plan have not been implemented. First, USHC has not reduced prices.[5] Rather, it reports negotiating higher rates on private, noncapitated contracts.[6] Second, outcome data documenting superior quality of care at USHC have not yet been used in marketing or contracting. However, these data are now being collected and verified internally and may ultimately be used for these purposes.

Although we reviewed a number of brochures, directories, presentations, and activity reports, USHC could not provide us with a comprehensive enterprise-wide marketing plan of the caliber we would expect from a $1.5 billion revenue company attempting to establish a new identity in a highly competitive market. However, marketing plans do exist for some product lines such as cardiac and children's services.

As summarized in Table 1, the number of highly complex cases, defined using diagnostic related groups (DRG)[7] case weights, increased by 9.7 percent during the first two years of the merger.[8] Although the criteria used to classify cases as highly

[5] Those we spoke with at USHC during our current audit expressed the opinion that lowering prices to gain market share was an unrealistic strategy and too simplistic an approach.

[6] A capitation payment is a predetermined fixed payment per member per month for which the provider agrees to supply a defined set of medical services for a certain period of time.

[7] Diagnostic related groups (DRG) are a set of approximately 480 inpatient diagnoses established under Medicare that groups together patients with similar conditions or processes of care. Medicare and some private payors pay hospitals a fixed fee per admission that varies by DRG.

[8] The definition of highly complex cases used in Table 1 is different from that used in the merger business plan prepared by Ernst & Young. Consequently, the numbers reported here are not directly comparable to those in the pre-merger business plan. The table defines highly complex cases as those in DRGs with case weight indices of 2.25 or greater for adults and 1.50 or greater for pediatrics. These criteria result in the classification of 12,857 cases as highly complex in fiscal year 1996-97. In contrast, the criteria used in the merger business plan, which was based on severity levels across all DRGs, resulted in the classification of 16,669 cases as highly complex. Although the method used in the merger business plan is preferable, USHC could not provide data based on that criteria.

complex are not identical to the criteria used in the merger plan, the data indicates that growth in the number of highly specialized cases since the merger has been roughly in line with the growth anticipated in the pre-merger business plan.

Contrary to expectations in the pre-merger business plan, the number of less complex cases has also increased since the merger. Much of this unanticipated growth is attributable to the expansion of emergency room capacity at UCSF, which was unrelated to the merger. As shown in the table, admissions of emergency room patients increased by nearly 20 percent between 1997 and 1999.

TABLE 1

USHC—Annual Number of Discharges

	Fiscal Year 1996-97*	Fiscal Year 1997-98*	Fiscal Year 1998-99†	Variance Between 1997 & 1999	Percent Variance Between 1997 & 1999
Total discharges	55,252	58,397	60,816	5,564	10.1%
Highly complex‡	12,857	13,146	14,100	1,243	9.7
Less complex	42,395	45,251	46,716	4,321	10.2
Emergency room source§	12,671	14,179	15,110	2,493	19.7
Other sources	42,581	44,218	45,706	3,125	7.3

Source: August 19, 1999, memo from Michael Thomas, Vice President Strategic Planning, USHC

* USHC's fiscal year runs from September 1 through August 31.

† The September 1998 through June 1999 numbers were annualized.

‡ Classification as highly complex based on DRG case weights that differ from the merger plan.

§ Classification as "emergency room sources" are cases that were admitted through the emergency room.

Like Other Hospitals, USHC Faces Deteriorating Reimbursement Rates

Like many other medical facilities throughout California, USHC has experienced deterioration in reimbursement rates from federal and state government programs. The federal Balanced Budget Act of 1997 (act) had a significant impact on compensation

to hospitals—particularly teaching hospitals. The act froze federal Medicare reimbursement rates for one year beginning in 1998 and restricted rates to rise more slowly than the rate of hospital cost inflation thereafter. To further compound the revenue situation, federal compensation to teaching hospitals for the additional costs of medical education was also reduced. Since 1997, state Medi-Cal compensation rates have not risen as rapidly as hospital costs. USHC estimates that uncompensated cost for treatment of Medi-Cal patients totaled approximately $80 million in fiscal year 1997-98. Further, because of changes in patient mix, USHC's children's hospital no longer qualifies for disproportionate share hospital[9] funds, reducing revenue by approximately $11 million annually.

Although reduced reimbursement rates have adversely impacted USHC, they were not unanticipated at the time of the merger.

Although these effects have adversely impacted USHC, they were not unanticipated at the time of the merger. For example, an analysis prepared by the director of finance at UCSF prior to the merger estimated that the act would reduce Medicare funds between 1998 and 1999 by $6.2 million.[10] By comparison, a recent analysis prepared by USHC estimates that its reduction as a result of the act will actually total $10 million between these years.[11] Management anticipated some of these reductions prior to the merger, but we found no evidence that they were incorporated into the forecasts prepared by Ernst & Young in its pre-merger business plan. Specifically, the level of detail provided to us by Ernst & Young to support its projections was not sufficient to determine what it assumed, either explicitly or implicitly, about payment rates from government programs.

One factor that was not anticipated in the pre-merger business plan is the movement of patients to lower-reimbursing health plans. Although USHC reports that contract rates have increased in both 1998 and 1999, enrollees have reportedly rotated out of health plans that compensate health care providers more generously and into lower-paying plans. This has reportedly decreased the gains USHC received from its higher negotiated contract rates and reduced expected contract revenue.

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[9] These state funds are available to hospitals that serve a significantly larger than average share of indigent and low-income patients.

[10] Source: "UCSF Funds at Risk" analysis dated July 8, 1997. The analysis identifies potential reductions in Medicare base rates, disproportionate share hospital payments, and indirect and direct medical education payments.

[11] Source: "UCSF Stanford Health Care," presented at the City of San Francisco board of supervisors meeting on April 7, 1999.

One factor not anticipated is the movement of patients to lower-reimbursing health plans.

The impact of deteriorating reimbursement rates appears to have been greatest at UCSF because of the higher proportion of Medicare and Medi-Cal patients served there. In addition, UCSF reportedly has a larger number of privately insured patients enrolled in the HMOs that negotiated the lower reimbursement rates to providers. In contrast, Stanford's hospitals have a greater proportion of smaller preferred provider organizations[12] that have generally been less effective at reducing reimbursement rates. Thus, revenue per patient day among private payors declined more significantly at UCSF, nearly 14 percent between 1998 and 1999, than at Stanford, which declined only 1 percent. The net effect of these forces on average revenue per patient day by type of payor can be seen in Figure 10 in Appendix B.

As Anticipated, USHC Achieved Cost Savings by Merging

During the first four years of operation, the merger plan called for USHC to achieve cost savings of nearly $111 million as the result of instituting best practices, consolidating duplicate resources, and increasing purchasing volume to qualify for additional discounts from suppliers. For example, it expected to save over $4.5 million annually by closing a warehouse to reduce material inventory levels and by receiving discounts on larger volumes of consolidated purchases. Further, the pre-merger business plan included $3 million in annual savings through reductions in senior management positions. Consolidation of clinical laboratories and economies of scale in testing were anticipated to save an additional $2 million annually. Moreover, USHC expected to decrease capital expenditures by $4 million over five years as a result of the merger. It knew it would incur $25 million in information system costs, but the pre-merger plan anticipated savings of over $29 million in other capital expenditures.

For the two years ending August 31, 1999, USHC estimates it will save $17 million in operating expenses, and it appears to be on track to exceed the total amount projected for the four-year period. USHC realized savings mainly through consolidation of corporate structure and reduction of overhead expenses. For

[12] A preferred provider organization, or PPO, is a health care benefit arrangement that offers financial incentives, such as low out-of-pocket prices, to enrollees who obtain medical care from a preset list of physicians and hospitals. A PPO still covers services obtained from out-of-network providers. In addition, PPOs generally reimburse hospital costs at a higher rate than HMOs.

example, in the areas of clinical laboratories, USHC informed us layers of management were eliminated, overall staff was reduced, contracting with outside laboratories was minimized, and testing was consolidated across sites. In addition, the clinical laboratories are currently exploring the option of contracting to perform laboratory tests for other hospitals in order to fully use USHC's lab capacity and raise additional revenue. Savings were also realized in finance and pharmacy areas.

Merger Expenses Are More Than Double What Was Expected

Merger expenses in the first two years soared to $79 million from the anticipated $36 million.

Although it reduced some costs, the merger increased USHC's expenses in other areas. The merger has actually cost USHC $79 million so far, more than double the $36 million expected for the first two years of operation. The difference results from unanticipated costs related to personnel, restructuring, administration, and one-time cost of collections. Although some of the merger costs will diminish over the next few years, others are fixed and must be paid annually. These include personnel costs such as paid time off for employees and administrative expenses such as human resources, audit, and legal services as discussed later in this chapter.

As part of its pre-merger business plan, Ernst & Young estimated that total merger expenses would cost USHC nearly $75 million over four years. Pension and health benefit costs of $66 million make up most of this expense. Although the University of California's overfunded pension plan would have allowed UCSF to avoid these costs had it not merged, the costs would still have been borne by the University of California. As a private corporation with its own pension plan, USHC must pay these pension-related costs out of pocket.

Other estimated costs of the merger included an increase in funds transferred to the UCSF and Stanford medical schools. The initial plan anticipated annual payments of $2.5 million to each school in the first year and a second payment of up to $2.5 million, divided equally between the two. The final Affiliation Agreement included specific language increasing medical school support by $10 million over four years—approximately $2.5 million per year. It also allows UCSF and Stanford to jointly approve any changes to the amount or type of support transferred to the schools.

USHC Underestimated Year 2000 Information Technology Requirements

Total planned capital investment has remained unchanged from the pre-merger business plan at $440 million over four years, but information technology investment is now projected to equal almost 30 percent of that total, diverting capital investment away from other areas. A number of factors contribute to this increase.

New information technology to replace inadequate systems will take a 30 percent bite out of the $440 million capital investment budget.

As part of its pre-merger business plan, USHC anticipated capital investment costs of nearly $25 million to unify UCSF's and Stanford's information systems and complete other system improvements. However, by March 1998 it was forecasting a cost of $95 million, and now the cost has risen to $126 million, over five times the original estimates. One of the reasons for this rise is that neither UCSF nor Stanford explicitly identified or budgeted costs to address potential Year 2000 (Y2K) problems at the time of the merger. As of March 1999, USHC estimated that the Y2K costs, with other information technology expenses and improvements that cannot be separated, will amount to $100 million.

More importantly, it became clear soon after the merger that UCSF's information technology infrastructure was inadequate for its needs. In addition to not having senior management in the information technology division, UCSF relied on outside consultants for its technology needs. Further, it lacked an order entry system that records clinical tests ordered, accumulates related test results, and automatically forwards amounts charged for tests to the finance department for payment. Additionally, UCSF used an archaic patient accounting system that could not be made Y2K compliant. Finally, UCSF's lack of a basic communications infrastructure reportedly required the replacement of e-mail systems, desk-top computers, personal computer networks, and even telephone systems. In its analysis, USHC estimates that roughly two-thirds of the $126 million in projected costs relate to underanticipated remediation, replacement, and upgrade costs at UCSF hospitals. These expenses would have been necessary whether the merger had taken place or not. Post-merger, they were necessary before any progress could be made to integrate clinical and management information systems across USHC as a whole.

USHC estimates that roughly two-thirds of the $126 million in costs relate to underanticipated Y2K remediation, replacement, and upgrades at UCSF's hospitals.

While USHC moves forward on major technology initiatives that entail a UCSF billing project, including scheduling, registration, and patient identification improvements, it also is installing a clinical system at Stanford that includes a Y2K compliant order entry and results reporting systems. Once these projects are completed, USHC will implement UCSF's billing project at Stanford and install Stanford's clinical system at UCSF. The strategy being pursued by USHC involves implementing common systems across hospitals, using as few vendors as possible, and not modifying or customizing purchased systems. Key elements of these systems are already complete, and we have been informed that the remaining major projects will be completed within budget by October 1999.

USHC Added Employees Rather Than Reducing Staff

Prior to the merger, USHC anticipated a reduction of 120 employees[13] over a five-year period with 61 management and 59 nonmanagement positions eliminated in equal proportion at UCSF and Stanford. At the same time, it anticipated an increase of between 106 and 212 employees to serve the expected increase in highly specialized cases. The net effect, prior to the merger, was estimated to range from a reduction of 14 to an increase of 92 employees over five years.

Only 52 percent of the nearly 600 new clinical employees relate to patient volume increases—a significant number are unexplained.

However, as of May 1999, USHC has added nearly 1,000 employees, excluding transfers from the two medical schools and universities. Of this increase, 597 were in clinical areas; 317 were in finance, administration, and information technology; and 54 were in materials and facilities. Approximately 52 percent of the clinical increase, or 313 employees, was attributable to patient volume increases since the merger (assuming pre-merger ratios of direct-patient-care staff to patients). This leaves a significant portion of the new clinical employees unexplained. Some increases had already been scheduled prior to the merger; for example, 25 employees were hired to avoid the need to divert emergency cases from UCSF to other hospitals. However, some portion must be attributed to the inappropriate addition of staff as volume increased.

Several merger-related factors contributed directly to the increase in employees in finance, administration, and information technology. Based on our interviews, some of the functions these new employees perform were formerly covered centrally

[13] As used here, "employees" relate to full-time equivalent employees.

by the University of California system for all its schools. UCSF underestimated the level of support that it received from this source prior to the merger and the additional staff needed to perform the functions after the merger at USHC. In addition, the integration of diverse financial and management information systems across hospitals required more personnel than USHC anticipated. Finally, additional employees were needed to help resolve problems arising from the change in tax identification and billing numbers and the resulting drop in cash collections following the merger. In addition to salary costs for these employees, USHC incurred $10 million in unanticipated collection agency fees to address this latter problem.

Unreliable Systems and Untimely Information Contributed to Cost Increases

A lack of integrated and timely management information also contributed to cost increases following the merger. If managers have no timely way of monitoring trends in staffing and other expenses, they cannot take timely action to control them. Preliminary analyses of operating and financial results were typically not available until two to three months after the close of a period. For example, USHC did not have the financial results for the September to November 1998 quarter until the end of January 1999 and did not analyze these results until the end of February. These time lags almost certainly contributed to a delay in recognizing the magnitude of the deterioration in financial performance during the first quarter of fiscal year 1998-99.[14] The lack of information also limited USHC's ability to measure its performance against goals and hold management accountable. However, USHC now produces more timely financial reports. For instance, USHC reported the financial results for March through June 1999 within 30 days of each month.

Time lags almost certainly contributed to a delay in recognizing the magnitude in its financial performance.

In its recovery plan, The Hunter Group, a consulting firm hired by USHC, recommended more than 10 new reports with data on activity, profitability, and progress toward goals across hospitals and by payor categories. This plan also called for daily, weekly, monthly, and quarterly information for executive, operating, and medical officers. Details of the plan are discussed in Chapter 2.

[14] USHC's fiscal year begins on September 1 and ends on August 31.

The problems of integrating information systems (and, in some cases, creating new infrastructure), as well as the preoccupation with Y2K issues, has contributed to USHC's lack of timely and integrated data. System upgrades associated with resolving Y2K problems will likely provide the infrastructure needed for improvement in this area.

The Cost of Supplies and Medicine Increased Despite Larger Volume Purchases

A final factor contributing to USHC's present financial crisis is that post-merger drug costs and expenses on operating room and catheterization lab supplies increased at a faster rate than patient volume. Consistent with national trends of rapid increases in pharmaceutical costs and other supply costs, pharmacy supply costs rose 20 percent and operating and catheterization lab supply costs rose 5 to 10 percent in the first year of the merger.

CHAPTER CONCLUSION

USHC has achieved only limited integration of its two faculty medical staffs and has largely failed to consolidate its clinical programs in the two years since the merger. As a result, the conditions that were expected to give rise to improved clinical procedures, enhanced health outcomes, and lower cost medical care have not been achieved to the degree anticipated. A number of factors, including unplanned costs and lower than planned reimbursement rates, have contributed to USHC's failure to reach estimated profits of $65 million in the first two years after the merger. ■

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CHAPTER 2

Although It May Achieve More of the Intended Benefits in the Future, the Long-Term Success or Failure of UCSF Stanford Health Care Is Still Unknown

CHAPTER SUMMARY

By autumn of 1998, UCSF Stanford Health Care (USHC) was aware that it was unlikely to meet the financial goals projected in its merger business plan and began work with consultants to develop a recovery plan. This plan focuses on cost reductions, including $170 million of cuts in personnel, supplies, and overhead over a three-year period. It is reasonable to believe that these reductions can be achieved. However, the consultants' current forecast indicates that these cuts alone will not be sufficient to return USHC to ongoing profitability.

To address the need for further improvement in profitability, the consultants also developed an "inventory of opportunities" for USHC to consider. These opportunities go beyond the initial cost-cutting and call for revenue growth through payment rate and volume increases, reductions in medical school support, and possible changes in the services provided at Mount Zion Hospital. However, the opportunity inventory is still at an early stage of development. The consultants' recommendations, which have not yet been adopted by the USHC board, are currently less specific than those in their recovery plan, and the opportunities dealing with medical school support and Mount Zion Hospital are more politically charged. Thus, it is difficult to determine the likelihood of achieving the projected results from these opportunities.

Although the pre-merger business plan projected a $107 million profit for the next two years ending in August 2001, the consultants project only a $47 million profit if the recovery plan and additional opportunities are successfully implemented in full. Using the consultants' fiscal projections, we separated the $47 million profit into results related to merger activities and results that may have occurred had the merger not taken place.

Based on our analysis, we estimate that the merger may realize a gain of $140 million from merger activities compared to a loss of $93 million that UCSF and Stanford may have had if they had not merged.

Beyond the cost reductions and opportunities currently being considered or implemented, USHC will have to develop a new business plan that should include specific strategies to pool resources and develop additional programs to enhance revenues and cut costs without compromising medical care and medical education. Unless USHC finds a means of dealing with continuing financial and political pressures, it faces the possible dissolution of the merger.

USHC HIRED CONSULTANTS TO DEVELOP A RECOVERY PLAN AND SUGGEST GROWTH OPPORTUNITIES

The consultant devised a plan to cut costs by $170 million annually.

When financial results for the first quarter of fiscal year 1998-99 (the quarter ended November 30, 1998) became available, it was evident that USHC's financial performance had begun to deteriorate significantly. To address the decline in profitability, USHC assigned one of its consultants to identify cost reductions and performance improvement opportunities. In March 1999, the consultants presented a recovery plan that identified $170 million of annual cost reductions. Although they identified these reductions after a comparison of expense levels between USHC and other comparable hospitals, USHC program and department management are responsible for developing specific plans to achieve the cost reduction targets. Although some of these plans have been developed and are currently being implemented, others are still evolving.

To determine how (or even whether) USHC might be able to return to profitability by August 2001 and beyond, the consultants developed an inventory of opportunities that identified $100 million in additional performance improvement options. The inventory of opportunities, presented to USHC's board of directors in July 1999, has yet to be adopted by USHC.

If USHC has determined that its prior strategy of integrating clinical practices and consolidating product lines to improve medical outcomes and lowering cost to gain additional revenue is no longer feasible, it will need more than the current plans to succeed in the long run. It must develop a strategic business

plan that clearly details the strategies and methods it will use to pool its talents and resources and improve medical care, educational opportunities, and its financial position. Moreover, USHC will need to develop an adequate information system that allows it to determine if the specific goals in the new business plan, whatever form it takes, are being met.

The Consultants Mainly Focus on Cost-Cutting to Break Even and Ensure Future Profitability

Baseline forecasts by the consultants show a dramatic deterioration in the expected financial performance of USHC over the next three years. Profits, which totaled nearly $20 million at the end of fiscal year 1997-98, its first year of operation, became estimated losses of $66 million by the end of fiscal year 1998-99, and those losses are ultimately projected to increase to $218 million by fiscal year 2000-01. To improve performance, the consultants recommend cost reductions that will eventually reach $170 million per year. These savings, forecast to be fully achieved by August 2001, include cuts in personnel, reductions in supply expenses, and savings in other expenses. Although these savings, if achieved, would return USHC to a break-even point by August 2000, they alone are not sufficient to sustain break-even performance into the future. The consultants believe that without further improvements, USHC will sustain operating losses exceeding $50 million for fiscal year 2000-01.

An additional $100 million in performance improvements are recommended to return USHC to profitability.

To reach a targeted 3 percent profit margin, the consultants recommend additional performance opportunities totaling $100 million by the end of fiscal year 2000–01. Revenue growth, additional cost cuts, proposed reductions in financial support to the medical schools, and savings from changing the nature of services available at Mount Zion Hospital will all be needed to reach this goal. If USHC accomplishes all these improvements, the consultants project a modest $47 million profit in fiscal year 2000-01. This projection is based on the consultants' "best-case" scenario, which includes the elimination of inpatient services at Mount Zion Hospital as more fully discussed later in this chapter.

Cost-Cutting Is Required for Viability in the Health Care Industry

Without context, the cost cuts recommended by the consultants may seem severe. However, they assume that USHC should cut costs to bring its expenses in line with other teaching hospitals to better compete in the health care market.

Though the merger was intended to consolidate services, adopt best practices, and lower costs, USHC's expenses have increased more rapidly than its revenue. Further, since the merger, its expenses have grown more rapidly than those of its competitors. In 1998, USHC's average expense per patient discharge was $27,000. In contrast, the other University of California hospitals had an average expense of only $17,300 per patient discharge. An unknown amount of the difference may be caused by inconsistencies in the reporting of physician practice revenue and expense. As shown in Figure 1 on page 27, even before the merger, UCSF and Stanford had higher costs per patient discharge than their competitors. For instance, in 1996, UCSF spent more than $18,000 per patient discharge, whereas the average of other university hospitals and large hospitals in the region was $15,000 and $12,000, respectively. Given this, had the two entities not merged, they would still have needed to make significant cuts in expenses to remain competitive.

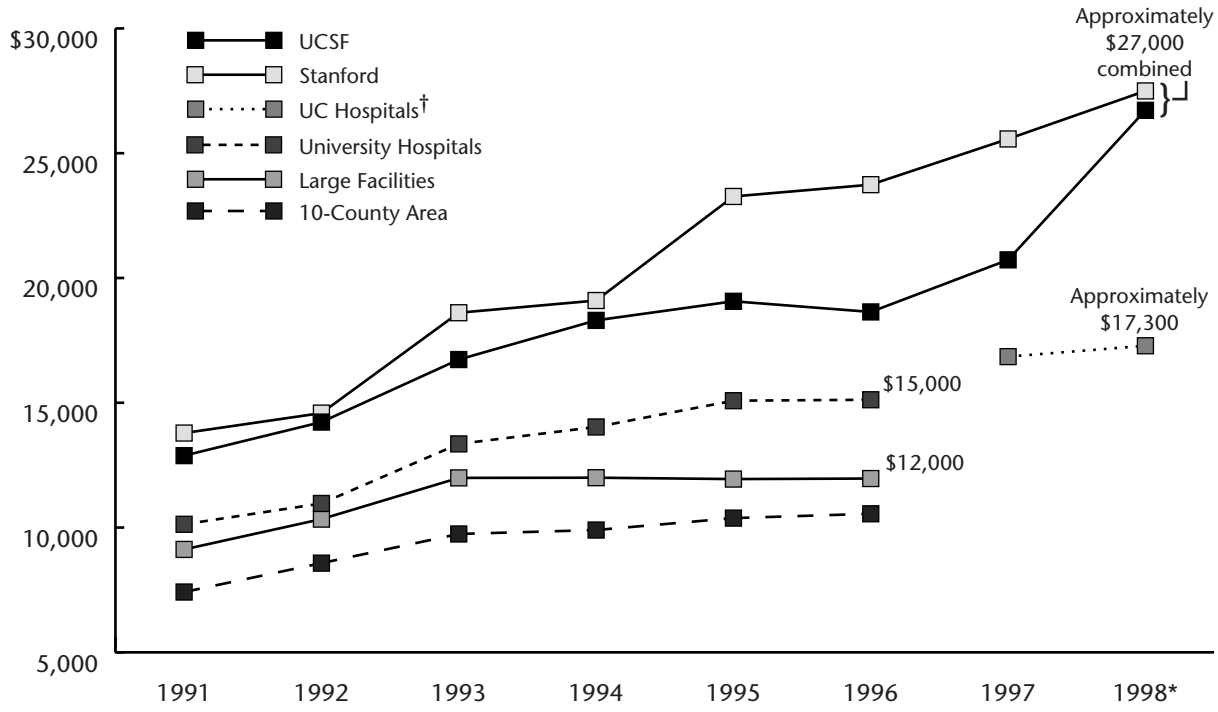
THE RECOVERY PLAN WILL CUT EXPENSES BY $170 MILLION ANNUALLY

In their March 1999 plan, the consultants focus on cutting expenses by $170 million annually by fiscal year 2000–01. This plan calls for USHC to make the bulk of the cuts, $112 million, by reducing the number of its employees. The second largest category of savings, $38 million, includes improving clinical resource utilization[1] and reducing supply expenses. The remaining $20 million is expected to result from savings in general and administrative costs such as consulting services. The timing of expense reductions is shown in Table 2 on page 28.

[1] There is no "set" definition of clinical resource utilization because it is an industry specific term and used in different ways. One definition of it is an attempt to monitor the uses of resources in treatments. It is also an attempt to improve efficiency of the treatment without negatively affecting, and sometimes improving, the quality of the outcome.

FIGURE 1

Total Operating Expense Per Discharge 1991 Through 1998
(Amounts in Thousands)



Source: OSHPD Annual Hospital Disclosure Report and OSHPD quarterly data.

* 1998 values are annualized based on 10 months of data except for Lucile S. Packard Children's Hospital which includes 12 months of data.

†Source: OSHPD and University of California "Hospital Activity and Financial Status Report", 1997 and 1998.

USHC Has Met Some of Its Targeted Staff Reductions

Personnel costs are the largest expense of USHC and other hospitals; thus, personnel reductions comprise the bulk of proposed savings. The pre-merger business plan forecast a reduction of only 120 employees over a five-year period combined with an increase of 106 to 212 staff over the same period to serve the anticipated increase in caseload. However, as previously discussed in Chapter 1, USHC has added almost 1,000 employees to its staff since the merger.

According to USHC, it needed to increase administrative personnel to cover a number of merger-related functions such as to address information technology infrastructure requirements at UCSF, resolve differences in accounting systems across campuses, and perform functions formerly provided by

TABLE 2

Timing of Expense Reductions
(Amounts in Millions)

Opportunity	Fiscal Year 1998-99	Fiscal Year 1999-2000	Fiscal Year 2000-01	Total
Personnel reductions	$84	$28	-	$112
Pharmaceutical and supply expense reductions	3	20	15	38
Other expense reductions	-	10	10	20
Total	**$87**	**$58**	**$25**	**$170**

Source: The Hunter Group, March 25, 1999, Recovery Plan "Executive Summary" p. 84. Timing of pharmaceutical and supply expense reductions modified based on discussions with The Hunter Group.

personnel of the University of California system. However, it appears that USHC did not control employee increases well immediately following the merger as discussed earlier in Chapter 1.

The consultants based their recommendations for personnel reductions on October 1998 employee levels and external benchmarks of staffing levels from other academic hospitals. Specifically, the plan called for a reduction of 2,005 employees, or 20 percent of USHC's work force. Administration and support services positions account for most of the reductions. Table 3 shows the reductions by department proposed by the consultants.

Personnel reductions are currently being implemented at USHC roughly as recommended by the consultants. Specifically, a total of 1,965 reductions are scheduled from May 1999 through September 2000, with 1,549, about 75 percent, to be eliminated by the end of August 1999. Reductions include 1,041 staff in clinical areas; 322 in materials and facilities; and 602 in finance, information technology, and other administration. According to USHC, only 40 percent of the reductions will be accomplished through layoffs; 27 percent will be achieved through attrition or voluntary resignations. USHC will accomplish the remainder through reduction of hours, elimination of temporary help, and other means. Table 4 on page 30 shows the schedule of reductions as of early June 1999.

TABLE 3

Proposed Personnel Reductions

Department	October 1998 Employees*	Reduction	Percent Reduction
Administration	2,404	976	40.6%
Ambulatory service	509	65	12.8
Diagnostic services	1,230	74	6.0
Patient units	2,958	243	8.2
Support services	1,375	368	26.8
Therapeutic services	1,496	257	17.2
Other	150	22	14.7
Total	**10,122**	**2,005**	**19.8%**

Source: The Hunter Group, March 25, 1999, Recovery Plan "Executive Summary" p.47.

* As used here, employees relate to full-time equivalent employees.

The consensus among department heads whom we interviewed in late July 1999 was that they had already made the necessary reductions or that reductions were on target. This is consistent with recent information we reviewed in USHC's *FTE Monitoring Report*. This report indicates that as of June 26, 1999, personnel reductions were within 17 of those scheduled. Based on that data, 2 of 11 departments had met or exceeded their total reduction targets.

The finance and information technology departments have scheduled personnel reductions later than other departments and consequently have combined reductions of 284 employees remaining to meet their targets. As discussed in Chapter 1, both of these departments experienced significant increases in personnel—some of which were directly related to the merger. In the finance department, additional personnel were hired to integrate billing and accounting systems across sites, develop an enhanced financial reporting system, and deal with relatively shorter term "emergencies" such as the disruption in cash collections due to changes in USHC's tax and billing identification numbers. Increased staffing in the information technology department was necessary to remedy historic underinvestment in infrastructure at UCSF, including the replacement and

TABLE 4

Timing of Personnel Reductions

Month	Number of Reductions
May 1999	367
June 1999	624
July 1999	325
August 1999	233
Fiscal Year 1998-99 Total	**1,549**
September 1999	161
January 2000	90
June 2000	122
September 2000	43
Fiscal Year 1999-2000 Total	**416**
Total	**1,965**

Source: USHC, June 8, 1999, "Progress Toward Meeting FTE Reduction Targets."

upgrade of telephone systems, e-mail capability, computer networks, and Y2K problems. The installation of software and hardware systems is expected to be complete by October 1999. As a result, the increased numbers of personnel in the finance and information technology departments will no longer be necessary once their merger-related tasks are complete, and the two departments should be able to reach their target reductions by August 2000 as scheduled.

Some Medical Staff Have Cooperated Across Sites to Reduce Supply Expenses

Before the merger, UCSF and Stanford expected significant cost savings from the standardization and consolidation of purchased products and supplies. However, since the merger, all hospitals have been faced with rapidly rising costs of drugs and medical supplies. According to USHC, drug expenses at its UCSF hospitals increased significantly faster than the 9 percent increase in patient activity and the 4 percent to 5 percent underlying annual cost trend.[2]

[2] From a document prepared by USHC titled "What Happened to Operating Income Between FY97 and FY99?" June 16, 1999.

Even if USHC cuts its supply and pharmaceutical budgets by $38 million, most other hospitals spend less.

To identify and recommend supply expense reductions, the consultants used comparative benchmarks from other university teaching hospitals and concluded that USHC could achieve $38 million in savings annually by cutting the costs of operating room supplies, pharmaceuticals, emergency room supplies, laboratory supplies, and dietary services. Even if it reduced its supply expenses by this amount, 75 percent of all university hospitals would still be operating with a lower supply budget. These reductions are scheduled to increase as more specific opportunities for savings are identified by USHC. In their recommendations, the consultants targeted reductions of $3 million in fiscal year 1998-99, $20 million in fiscal year 1999-2000, and $15 million in fiscal year 2000-01.

Regardless of cost increases, standardization of supplies and improvements in clinical resource utilization are crucial to achieve the targeted cost savings. Ideally, standardization and adoption of best practices would take place across all USHC hospitals. However, except in children's services, work in this area has mainly been conducted on a site-by-site basis with the chief medical officers and their staff at each hospital. Even on a site-by-site basis, the standardization and improvements in resource utilization will result in some savings.

We also found some evidence of cooperation across sites. For example, a very expensive drug used in the treatment of solid organ transplant patients at Stanford was not used at UCSF, without any difference in morbidity. Across site discussions led to savings from curtailing the use of the expensive drug at Stanford. In another example, an analysis of contrast media use allowed radiology managers to negotiate reduced prices with their vendor for savings of over $200,000.[3]

Even on a site-by-site basis, standardizing supplies and improved resource utilization will result in some savings.

Most importantly, supply standardization and improved clinical resource utilization require the involvement and commitment of the medical staff. The opinion was expressed to us that supply expense reductions beyond certain levels would lead to substantive clinical issues. Although we have been informed that USHC has already implemented $5 million of the $38 million savings and that work groups are in place to identify additional opportunities, physician "buy-in" is critical. Unless the medical staff are closely involved in identifying opportunities for savings and are committed to the need to achieve them, the $38 million goal may not be reached.

[3] From a USHC document titled "Proposed FY99 Operating and Capital Budget," August 21, 1998.

Miscellaneous Expense Reductions Are Likely to Occur

The consultants also recommend reducing general and administrative expenses by $20 million per year—$10 million annually for fiscal years 1999-2000 and 2000-01. Two-thirds of these savings, or $13.2 million, represent reductions in consulting and purchased services costs, notably to the consultants and outside vendors. However, these savings may not occur as soon as originally anticipated if interim management provided by the consultants are not promptly replaced by full-time employees.

Other general and administrative expenses include dues and subscriptions, travel, printing, education and training, and inter-hospital contracts. USHC has targeted each remaining category to be cut by an estimated 30 percent, for total savings of $6 million. Table 5 shows our assessment of the likelihood of achieving the $170 million in cost savings identified by the consultants.

TABLE 5

Likelihood of Achieving the Initial Savings Projected by Consultants (Amounts in Millions)

	Three-Year Total	Specificity of Plan	Likelihood of Success
Personnel reductions	$112	Clear	Good
Pharmaceutical and supply expense reductions	38	Vague	Fair
Other expense reductions	20	Clear	Good
Total	**$170**		

CONSULTANTS PROJECT A FUTURE PROFIT IF ADDITIONAL OPPORTUNITIES ARE MET

In addition to their recovery plan, the consultants inventoried other performance improvement opportunities that USHC should consider implementing to achieve profitability in future years. The potential for performance improvement is estimated to range between $114 million with a "best-case" scenario and $53 million with a "worse-case" scenario. As shown in Table 6,

opportunities in the "best-case" scenario include $47.5 million in revenue growth and $66.5 million in additional expense savings. The additional expense savings include $12 million in reduction of medical school strategic support and $24 million from the discontinuation of inpatient services at Mount Zion Hospital. The "worse-case" scenario assumes that no growth in inpatient volume is achieved, that only half of expense reduction targets are met, and that Mount Zion maintains selected inpatient services. Opportunities identified by the consultants are under review but have not yet been adopted by USHC management.

TABLE 6

Summary of Performance Improvement Opportunities for Fiscal Year 2000-01 (Amounts in Millions)

Opportunity	UCSF Adult Services	Stanford Adult Services	Children's Services	Corporate Services	UCSF/Stanford Total
Revenue/program growth*	$16.6	$13.9	$17.0	-	$47.5
Expense reductions†	1.5	10.6	6.0	-	18.1
Program closure/ consolidation‡	24.0	-	2.5	-	26.5
Reallocation	-	(5.0)	5.0	-	0.0
Practice support	0.8	3.5	-	-	4.3
Strategic support§	6.0	4.0	2.0	-	12.0
Corporate services	-	-	-	$5.6	5.6
Total Opportunities	**$48.9**	**$27.0**	**$32.5**	**$5.6**	**$114.0**

Source: The Hunter Group, July 23, 1999, *Performance Improvement Opportunities,* p. 43.

* Impact of Average Daily Census growth of 20 beds on each of three sites (growth of 6 percent).

† Up to 2 percent beyond the productivity and nonlabor expense targets set in the $170 million project.

‡ Financial impact of Mount Zion option #1 or equivalent for north campuses.

§ Up to 10 percent reduction in support distributed equally between UCSF and Stanford.

USHC Faces Barriers and the Likelihood of Achieving Additional Opportunities Is Unknown

In their inventory of opportunities, the consultants also identified several barriers to the implementation of their recommendations. One of those barriers was the constraints on the analysis the consultants were able to perform because of the need to identify options quickly. Other barriers included the current high demands on USHC managers' time while other cost reductions are being implemented and the lack of current financial and management data. The consultants also note the need for USHC to develop a business plan that focuses primarily on developing new programs and increasing market share. However, executive management focus in recent months has been on cost reductions rather than revenue enhancements. Also considered an obstacle is the long lead time required to implement most of the performance opportunities under consideration. Other impediments noted by the consultants include space constraints at UCSF as services are currently configured; large capital investment needs for seismic, operational, and program growth projects; and the apparent focus by management on the needs of medical schools and faculty rather than the need to develop quality patient services.

Executive management focus in recent months has been on cost reductions rather than revenue enhancements.

Table 7 summarizes our assessment of the likelihood that USHC will achieve these opportunities based on the current state of development of these plans. The process of identifying, planning, and implementing these performance opportunities has only just begun. Thus, to a large extent, our assessment of the likelihood of achieving the stated goals reflects this early stage of development. If goals are adopted by management, and are vigorously and competently pursued, the likelihood of success could increase.

Not All Revenue Growth Opportunities Are Likely

The consultants' list of opportunities identified up to $47.5 million in revenue opportunities in two broad categories. First, payment rates greater than those in the consultants' baseline forecast are expected to add to revenue. According to the consultants, their projected increases reflect the actual or expected outcomes of contract renegotiations that have occurred since March 1999, and the expected outcomes of future compensation rate negotiations based on a contract-by-contract

review of current rates. The consultants believe these rates are achievable and conservative and we agree that these rate increases are likely.

TABLE 7

Likelihood of USHC Achieving the Additional Opportunities Inventoried by the Consultants (Amounts in Millions)

	Three-Year Total	Specificity of Plan	Likelihood of Success
	("Worse-Case" to "Best-Case" Scenarios)		
Revenue growth	$17.7 to 47.5		
Payment rate increase		Clear	Good
Program growth		Vague	Poor
Expense reductions	10.3 to 20.6	Vague	Unknown
Corporate services	2.8 to 5.6	Vague	Unknown
Practice support reductions	2.2 to 4.3	Vague	Unknown
Medical school reductions	6 to 12.0	Vague	Unknown
Mount Zion options:			
1—Outpatient only	24	Clear	Fair
2—Outpatient and short-stay	14.1	Clear	Good
3—Move programs to Mount Zion	(3.1) to 2.6	Clear	Good

In addition to compensation rate increases, the inventory of opportunities establishes revenue increases based on growth in inpatient volume by August 2001 in excess of the 1.5 percent annual growth incorporated in the consultants' baseline forecast. However, we do not believe increases in patient volume are likely. Under "best-case" assumptions, USHC's average daily census is projected to increase by 20 patients in adult services at UCSF, 20 patients in adult services at Stanford, and 20 patients in children's services. These growth targets represent a 6 percent increase over the inpatient volumes assumed in the baseline forecast. This growth rate assumption was reportedly chosen

because it is equal to the growth in volume achieved during the first two years of the merger. Under "worse-case" assumptions, no growth in inpatient volume over the baseline is forecast.

Because demand for inpatient services is flat or falling and USHC lacks plans to achieve targets, we believe increased patient volume is unlikely.

The opportunities identified by the consultants do not specify how growth in inpatient volume will be achieved. At present, the 6 percent increase in volume represents only a proposed strategic goal rather than the projected outcome of programs that have either been identified or are currently in place. To achieve the goal, USHC should prepare a business plan that identifies opportunities for growth and develops marketing strategies to address those opportunities. The consultants expressed confidence that these growth targets are achievable, particularly in light of the growth achieved during the first two years of the merger. However, due to the current trend of flat or falling market demand for inpatient services and the lack of specific plans or programs to achieve the growth targets, we consider it unlikely that this increase in patient volume will be achieved by August 2001. Moreover, the "worse-case" scenario, in that no incremental patient volume is achieved, seems to be an acknowledgment of this possibility.

It Is Unknown Whether Cost Savings Are Likely to Occur

Although identified opportunities reduce expenses by nearly $21 million below levels of productivity and supply savings already targeted in the original recovery plan, these opportunities only represent strategic goals or targets at this time. The likelihood of achieving the goals is unknown until management endorses them and develops specific tactical plans.

Of these strategic or target goals in the "best-case" scenario, almost $11 million is expected within Stanford's adult services from reductions in expense per patient discharge by an additional 2 percent over the initial cost reductions. In addition, the consultants expect reductions within children's services to levels "consistent with regional and national benchmarks." Other opportunities include a $2.5 million reduction from the consolidation of children's services at one site and a $1.5 million reduction from the consolidation of clinical adult services and related office space into space owned by UCSF, thereby reducing the size and cost of leased space.

We were informed that explicit plans exist for achieving the $4 million in savings from the reduction in lease expense and consolidation or closure of some children's clinical service.

However, USHC has no specific plans yet for achieving the remaining expense reduction targets. To realize the identified opportunities, the consultants call on USHC to develop a business plan, but the consultants do not identify specific areas of savings or the likely distribution of these savings between personnel reductions and other sources.

The consultants set another goal to reduce expenses in the area of corporate services by an additional $5.6 million. Again, because this appears to be only a strategic target at this time, the likelihood that USHC can achieve the goal will be unknown until it fully develops specific tactical plans and management endorses them. At this time, the plan of additional opportunities identifies this saving only as coming from labor, supplies, general, and administrative expenses. USHC expects that completion of Y2K projects and additional conversions and upgrades of information systems will help achieve these savings. Further, reduced overhead requirements resulting from a net reduction of 3,000 admissions at Mount Zion are expected.

Implications From Proposed Reductions in Physician Practice Support Are Unknown

Physician support totaled $20.5 million in fiscal year 1998-99, ranging from $148,000 at UCSF to $290,000 at Stanford, per primary care clinical employee.

In their list of opportunities, the consultants propose $4.3 million in savings to be realized from reductions in physician practice support[4] payments. However, any plan to reduce support for physician practices is likely to meet with opposition from doctors and medical schools administrators. Without support from physicians for the performance improvements, we consider it unlikely that these reductions will be successfully implemented. In addition, hidden long-term costs from losing faculty and staff may result.

The consultants indicate that physician support will total $20.5 million in fiscal year 1998-99. This represents an average level of support of $217,000 per primary care faculty member, physician, resident, or nurse practitioner (clinical employee),[5] ranging from $148,000 at UCSF to $290,000 at Stanford. The consultants' report indicates that "Studies on community and academic medical center support of network practices are limited. Available studies suggest that the range of hospital support

[4] USHC provides support to full-time and clinical faculty of the medical schools and community physicians in primary care that operate medical practices as part of an integrated health care network.

[5] Source: "UCSF Stanford Performance Improvement 'The $100 Million Project'", p.30. Clinical employees include faculty, physicians, residents, and nurse practitioners.

The level of support to medical schools is difficult to determine and much of the money transferred represents compensation for services provided.

reported is most often between $40,000-$90,000, depending on several variables...". [6] The consultants recommend reducing the average level of physician support to faculty and community primary care practices at UCSF to $140,000 in fiscal year 1998-99, $125,000 in fiscal year 1999-2000, and $100,000 in fiscal year 2000-01. Over the same period, it recommends reducing support at Stanford to $200,000, $150,000, and $125,000. Under "best-case" assumptions, the consultants propose savings of $4.3 million from these reductions by August 2001. The benchmarks cited by the consultants suggest that savings in this area may be achievable. However, the implications of reductions of this magnitude to these primary care practices are unknown.

Strategic Support Reductions May Be a Decisive Issue

In addition to physician support, USHC also provides strategic support[7] payments to the two medical schools. Although the primary financial goal of the merger was to enhance the long-term financial prospects for UCSF and Stanford so the level of strategic support provided to the medical schools could be maintained or increased, the consultants also propose reductions in these support payments. Prior to the merger, neither UCSF nor Stanford routinely summarized and reported the level of support they furnished to their medical schools.[8] The complexity of the relationship between medical schools, their faculties, and the hospitals makes it difficult to clearly determine the level of support. Further, much of the money transferred from the hospitals to the schools and their faculties represent compensation for services provided. To the extent that these transfers are at market rates, it may be a mischaracterization to refer to them as "support."

In April 1999, USHC management and the board of directors requested a more rigorous inventory of strategic support to the medical schools, including both explicit and implicit payments. Although this analysis is not yet complete, preliminary findings

[6] Source: "UCSF Stanford Performance Improvement 'The $100 Million Project'", p. 29.

[7] The term "strategic support" broadly defined includes explicit and implicit transfers from USHC to the schools of medicine. Payment categories include medical school program support for business plan development, chairperson compensation, start-up and transition payments; profits from special laboratories such as infusion, echocardiology and MRI/CT services; medical program direction including payments for physician, administration and management services; and teaching support including direct medical education payments.

[8] UCSF and Stanford do not appear to be unique in this respect. Most academic hospitals do not explicitly report the level of support provided to affiliated medical schools.

indicate that transfers will be between $110 million and $115 million, or approximately 10 percent of USHC's operating expense, for fiscal year 1998-99. However, the medical schools have not yet confirmed these preliminary results. The lack of comparable benchmarks makes it difficult to determine how this level compares to support provided by other academic medical centers. However, UCSF and Stanford medical schools seem to be receiving equal amounts, with preliminary results indicating that UCSF will receive 48 percent of the total transferred while Stanford will receive 52 percent.

As part of the "best-case" scenario in the list of opportunities, the consultants recommend reducing the level of support to each school by $6 million, producing total savings to USHC of $12 million in fiscal year 2000-01. As with other expense reductions, this amount represents a proposed target. The methods by which these savings would be realized, and the implications of such reductions to the hospitals and the schools, are unknown. For example, it has not been determined how a reduction in transfers would affect the level of services provided to USHC by the medical schools or whether some portion of the savings could be achieved by improving the efficiency with which the schools provide services to the hospitals.

Consultants recommend reducing support to each medical school by $6 million, thus saving $12 million during fiscal year 2000-01.

The probable impact of these reductions on physician recruitment and retention, and on the academic mission of the medical schools, is also unknown. Our interviews indicate that this opportunity may be particularly divisive. We observed a general perception that deteriorating performance at UCSF will cause large reductions in support for faculty practices and the medical school at Stanford. As a result, some faculty members at Stanford question whether the merger continues to be in their best interest. Nonetheless, explicit identification and reporting of the amounts transferred to the medical schools provide needed visibility to a major category of costs that has been largely hidden in the past.

Of All the Cost Savings, Proposals Surrounding Mount Zion Hospital Seem Most Developed

The most publicly sensitive recommendation in the consultants' list of opportunities outlines the financial savings USHC could realize from reconfiguring the services offered at Mount Zion Hospital. As detailed in Table 8 on page 41, the three options recommended for changing services at this location are as follows: (1) eliminate inpatient services at Mount Zion and

The consultants' most publicly sensitive recommendation outlines the financial savings USHC could realize from reconfiguring the services offered at Mount Zion Hospital.

consolidate volume at Moffitt-Long; (2) maintain only a short-stay unit at Mount Zion and move other patients to Moffitt-Long; or (3) increase the services offered at Mount Zion by moving cancer programs and patients from Moffitt-Long. A range of stakeholders have interests in the Mount Zion issue, including USHC, the UCSF medical school, the faculty and community physicians that practice at Mount Zion, employees of the hospital, and members of the community served by the facility.

Our review is limited to an evaluation of the likely financial impact on USHC of the various options under consideration. As part of our evaluation, we analyzed summaries of key assumptions, expected financial impacts, advantages and disadvantages of each option, and supporting financial schedules. Additionally, USHC personnel were available to answer our questions. The assumptions behind the analysis are reasonable and adequately documented given the level of analysis and planning that is generally appropriate for a strategic decision of this nature. Further, nothing that we reviewed indicated that the financial forecasts were biased. We conclude that the expected financial costs and benefits associated with each option as summarized in Table 8 are reasonable estimates upon which to base policy decisions concerning the future of Mount Zion. However, implementing the chosen option, assuming that any changes at Mount Zion are made, will likely require tactical planning beyond the level of planning that we reviewed.

TABLE 8

Mount Zion Cost Saving Options

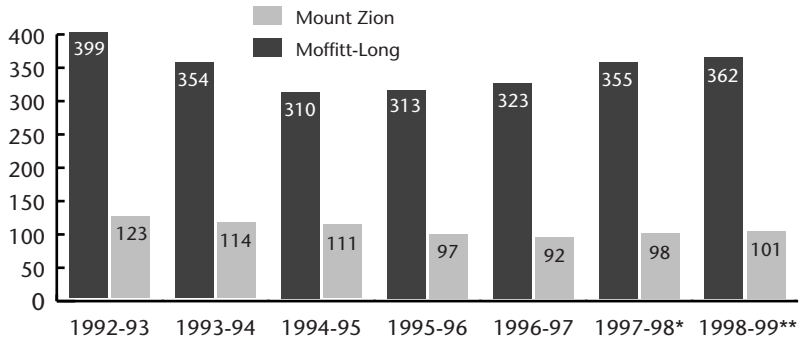
Options	Description	Key Assumptions	Financial Impact
1- Outpatient Services Only	Transfer inpatient and emergency services to Moffitt-Long. Continue all outpatient activities, including cancer center, at Mount Zion. Additionally, maintain faculty practices.	All faculty inpatient volume would transfer to Moffitt-Long, while community physician volume would transfer to other hospitals. Moffitt-Long plans to build an additional 16 critical care beds, 18 emergency room treatment stations, and 2 operating rooms to handle the Mount Zion patients.	**One-time costs:** $12.9 million for Moffitt-Long expansion while future seismic retrofit costs are avoided. **Increased Profit/Loss:** USHC estimates an approximate $24 million profit annually, which may be reduced by $2 million for every 10 percent change in the assumed number of patients. Moffitt-Long would lose $3.5 million to $7.9 million in professional fee income.
2- Outpatient and Short Stay Services Only	Transfer most inpatient and emergency services to Moffitt-Long. Retain a 72-hour short stay unit. Continue all outpatient activities, including cancer center, at Mount Zion. Additionally, maintain faculty practices.	Most faculty inpatient and related outpatient volume would transfer to Moffitt-Long, while most community physician volume would transfer to other hospitals. No capital investment in Mount Zion operating rooms or patient accommodations.	**One-time costs:** $10.6 million for Moffitt-Long expansion and $24.5 million in seismic retrofit at Mount Zion required by 2008. **Increased Profit/Loss:** USHC estimates a $14.1 million profit annually. Moffitt-Long would lose $2.7 million to $5.5 million in professional fee income.
3- Move Cancer Program and Patients to Mount Zion	Continue operation as full-service acute hospital. Transfer additional cancer program and patients from Moffitt-Long to Mount Zion. Fill excess capacity at Mount Zion with new patients.	Patient accommodations at Mount Zion are acceptable without further investment.	**One-time costs:** $12.0 million for additional operating rooms and $24.5 million in seismic retrofit at Mount Zion required by 2008. **Increased Profit/Loss:** USHC estimates a $3.1 million loss annually without additional cases at Moffitt-Long. USHC estimates a $2.6 million profit annually if all beds vacated at Moffitt-Long are "back-filled" with adult patients.

Source: Summarized from July 7, 1999 presentation to USHC board of directors "UCSF/Mount Zion Options."

Declining patient volume is one of the factors affecting the proposed changes at Mount Zion. Although inpatient volume declined at the two UCSF hospitals in the early 1990s, volume has increased somewhat recently as shown in Figure 2. Despite the recent rise, average daily census remains 9 percent below fiscal year 1992-93 levels at Moffitt-Long and 18 percent below levels during the same period at Mount Zion.

FIGURE 2

Trends in Average Daily Census
July Through June (Except as Noted)



* September 1997 through August 1998.

** Only six months, September 1998 through February 1999.

Source: Summarized from July 7, 1999 presentation to USHC board of directors, "UCSF/ Mount Zion Options."

In general, the idea that consolidating volume at one facility can reduce operating costs has been the basis for many recent mergers in the health care industry. As market demand for inpatient services has fallen, hospitals have been left with excess capacity. By closing or reducing the range of services offered at one facility, hospitals may be able to eliminate redundant overhead expense and spread the fixed cost of operation over a larger number of patients.

Some observers assert that the losses reported at Mount Zion have been overstated because of excessive overhead allocations or because of unprofitable programs located at the site. This assertion, even if true, is not relevant to the financial analysis of the various options outlined in Table 8 earlier. The appropriate economic analysis consists of determining how the expected cash flow of the combined enterprise is altered under each alternative. The *change* in expected cash flow to the combined enterprise resulting from each alternative is relevant, not the

level of reported profits at any particular site.[9] From this perspective, it makes no difference for the financial analysis whether Mount Zion is currently reporting operating gains or losses.

Eliminating inpatient services at Mount Zion would save the most money but has several drawbacks.

The consultants' first of the three options for Mount Zion provides the greatest expected savings to USHC. This option concentrates operating resources, capital, and management attention on operating one hospital rather than two at UCSF. However, "disruption" to teaching programs and constraints to growth of academic programs at UCSF are expected. In addition, the loss of community physicians to other hospitals is likely. The multidisciplinary nature of the cancer program may be threatened because emergency and critical care services will no longer be available to the community at the Mount Zion location. Alternatives for emergency backup for outpatients served at Mount Zion will need to be developed. It is doubtful that capacity at Moffitt-Long will be sufficient to absorb the patient volume from Mount Zion and growth in inpatient programs without significant reconfiguration.

The second alternative for Mount Zion would create less pressure on UCSF's operating room capacity than the first option and allow some faculty to avoid splitting activity between sites. This second option may have greater potential for maintaining relationships with community physicians and could also facilitate progression to cooperative family care and assisted outpatient care. Further, the loss of professional fee income to the medical school could be less. If circumstances change, option two also may offer greater potential to transition to a long-term hospital replacement. However, this second option is expected to result in $9.4 million less in operating savings than the first option. Disruption to teaching programs, loss of some community physicians, and loss of on-site emergency and critical care will also result under this second option. Some faculty surgeons will likely be required to split their activity between two hospitals, but the small size of the remaining inpatient facility (only 12 to 30 beds) may make patient care inefficient and management of patient acuity more difficult.

Under the third option, Mount Zion would continue as a full-service community teaching hospital for adult patients providing emergency and critical care services to the

[9] The principle of incremental or marginal cash flow analysis is fundamental to modern corporate finance. See, for example, R.A. Brealey and S. C. Myers, "Principles of Corporate Finance," fourth edition (New York, McGraw-Hill, Inc., 1991), pp. 95-98.

community. Medical student teaching programs would not be disrupted, and the option would maintain room for growth of academic programs. The cancer center would have more cohesion and more capacity for program growth as well. However, the financial savings available under either option one or option two would be lost. Further, to attract patients, additional capital investments may be required.[10]

The Consultants Identified but Did Not Evaluate Some Areas That Warrant Additional Consideration

The ongoing success of USHC will likely depend on its ability to successfully position itself as the preferred regional provider of high-quality, specialized care.

The consultants' recovery plan and inventory of performance opportunities focused primarily on decreasing expenses through reductions in personnel and through savings in certain supply and administrative cost categories. However, they left larger strategic issues and revenue enhancement opportunities mostly unaddressed, presumably to achieve improvements in performance as quickly as possible. Although this was probably a prudent short-term strategy, the ongoing success of USHC will likely depend on its ability to successfully position itself as the preferred regional provider of high-quality, specialized care. Several opportunities identified in the report prepared by the consultants should be more fully developed. These include the following:

- Consolidate selected highly specialized clinical services on one site.
- Plan and implement an aggressive program growth strategy.
- Further reduce and eventually eliminate risk contracting at UCSF.
- Identify other sources of strategic support funding for UCSF.
- Joint venture pediatric and obstetrical services in San Francisco.

[10] USHC has briefly discussed at least two other options for Mount Zion. One involves continuing operations for a specific limited period of time to allow stakeholders to identify alternative sources of support so that Mount Zion could continue to offer a more or less complete set of inpatient services. The other option involves using the site to construct a women and children's hospital in the future. We did not review financial analyses of these options.

In the Next Two Years, USHC May Realize Some Financial Benefits From the Merger

Cost reductions and performance improvement opportunities similar to those currently under consideration would have been necessary for UCSF and Stanford even if the entities had remained separate. To determine the potential effect of the consultants' recommendations on the two entities' financial position over the next two years, we performed an analysis to separate the revenues, expenses, and ultimate profit or loss that can be attributed to merged activities from the results that they could have achieved on their own. Based on this analysis, we estimate that USHC's merger-related operations may realize a gain of $140 million compared to a loss of $93 million that UCSF and Stanford may have had separately. Our calculations and complete analyses are presented in Appendix A. This indicates that USHC may be able to turn its losses (discussed in Chapter 1) into a more financially profitable situation over the next two years and realize more of the originally expected financial benefits. However, the long-term future of USHC is dependent upon whether it can successfully implement all the consultants' recommendations and fully integrate UCSF's and Stanford's medical staff and clinical programs.

THE FUTURE OF USHC IS QUESTIONABLE

Before UCSF and Stanford merged to form USHC, many critics and skeptics questioned whether the merger was the right move for the two entities. With USHC's recent financial losses and associated layoffs, the questions have resurfaced. Moreover, recent developments have many parties reevaluating the future of USHC and seem to put USHC on the brink of dissolution.

The presidents of UCSF and Stanford wrote their decision to "reassess the structure of the organization in light of the [two university's] multiple missions."

In an August 3, 1999, letter addressed to the chairman of the USHC board of directors, the presidents of UCSF and Stanford stated their decision to ". . . reassess the structure of the organization in light of the multiple missions [of their universities]. " The letter also stated that they were concerned that the current structure of USHC has not given them "the flexibility to deal with the complexities unique [to their respective institutions]. " On the other hand, they also stated that since the merger, USHC has made progress in meeting its goals to consolidate and combine the academic clinical services. Furthermore, the letter stated that the financial pressures on the university hospitals are even greater today than they were when USHC was established and

that for this reason they continue to believe in the original purpose of the merger. With this in mind, UCSF and Stanford have established committees to recommend an appropriate organizational model that will allow both entities to meet their public and private missions while benefiting from the opportunities of the merger. The deadline for these proposals is October 1, 1999.

In addition, both the chief executive officer and chief operating officer of USHC announced their resignations, effective August 16, 1999. USHC's board of directors has asked The Hunter Group, one of its consultants, to provide interim management. While UCSF and Stanford are considering the continuation of their merged relationship, they will need to determine if they still want to enhance their academic missions and combine their intellectual capabilities or if they are only interested in reducing administrative costs.

CHAPTER CONCLUSION

To reach even the substantially reduced profit level of $47 million for the two years ending August 31, 2001, as projected by the consultants, USHC must implement all the cost saving measures and revenue enhancements identified by the consultants in both their recovery plan and listing of opportunities. Many factors must be taken into consideration before deciding the best route for the original two entities and the community. ■

CHAPTER 3

UCSF Stanford Health Care Maintained Its Prior Commitment for Patient Access to Quality Care While Providing Continued Community Support

CHAPTER SUMMARY

Despite its failure to meet the financial goals of its merger, UCSF Stanford Health Care (USHC) has apparently continued its focus on providing access to quality health care. Based on several indicators, patients in the Bay Area appear to have more access to care since the merger. Furthermore, a survey of 25,000 patients and referring physicians[1] conducted by the hospitals indicates that patient satisfaction with the quality of care appears just as high as it was before the merger. In concert with its emphasis on access and quality of care, USHC continues to furnish services to low-income and vulnerable populations in the community. Through its operation of services such as clinics and health fairs, USHC has spent more money in the community than the hospitals did before they merged.

PATIENTS APPARENTLY CONTINUE TO HAVE ACCESS TO HEALTH CARE

Prior to the merger, the mission of the University of California, San Francisco Medical Center (UCSF) stated its responsibility to patients and the community "to provide personalized, competitively priced patient care." Most importantly, the mission statement indicated a special obligation to "translate advancements in research and science into new and improved systems of patient care." The mission of Stanford Health Services (Stanford) was "to deliver patient-centered, scientifically advanced care" as it aspired to be a leader "in both the art and science of health care." After the merger, USHC continued this

[1] A referring physician is one outside the USHC group of physicians who has referred a patient to USHC for care.

emphasis on patient access to quality care. To assist in meeting the levels of care desired, USHC established a Quality Improvement Division to provide leadership and coordination to hospital departments dedicated to improving the quality of care and satisfaction of its patients and families.

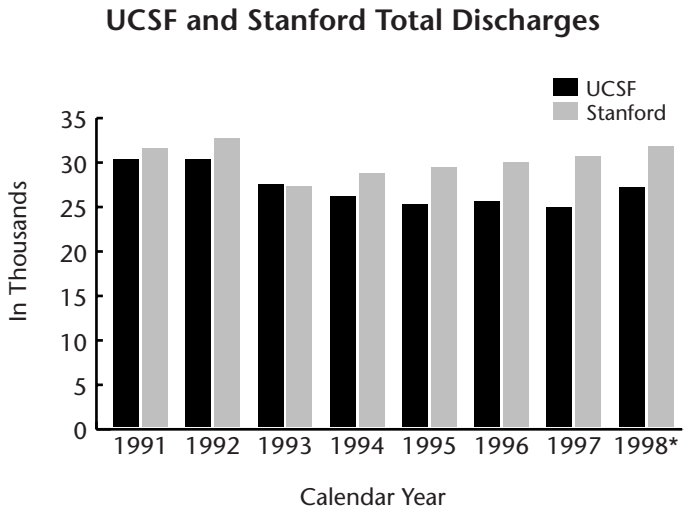
Before patients can receive high-quality care, they must have access to health care. As one measure of access, USHC administers a quarterly satisfaction survey to inpatients, outpatients, and referring physicians. Although most of the survey deals with satisfaction related to quality of care (the next section discusses these results), it does have several questions related to ease of patient access to USHC. Specifically, patients are asked to rate their satisfaction in areas such as the amount of time it takes to check into the hospital, ease of making appointments, and availability of physicians to answer telephone questions. USHC monitors patient comments and initiates corrective action if required.

A survey of 25,000 patients showed they were highly satisfied with access and quality of medical care.

Between October 1998 and June 1999, USHC surveyed over 25,000 patients and referring physicians. Overall, the results indicate that these groups were highly satisfied with access to care as well as the quality of care. However, the survey did elicit some complaints related to access issues such as lack of adequate parking, lack of communication regarding delays in service, and problem interactions with administrative departments.

We also analyzed hospital data reported to the Office of Statewide Health Planning and Development (OSHPD) to determine accessibility to care. Specifically, inpatient days and discharges can be used to track the number of patients who had access to and received care from the hospitals. Although the overall number of inpatient days and discharges per 1,000 persons in the Bay Area has steadily decreased for all hospitals over the last two years, USHC has actually experienced increases in its reported inpatient days and discharges since the merger. Using this as an indicator, patients apparently have more access to care since the merger. Figure 3 shows the total discharges for both UCSF and Stanford between 1991 and 1998.

FIGURE 3



Source: OSHPD Annual Hospital Disclosure Report and OSHPD quarterly data.

* 1998 values are annualized based on 10 months of data except for Lucile S. Packard Children's Hospital, which includes 12 months of data.

PATIENTS SURVEYED THINK HIGHLY OF CARE PROVIDED BY USHC

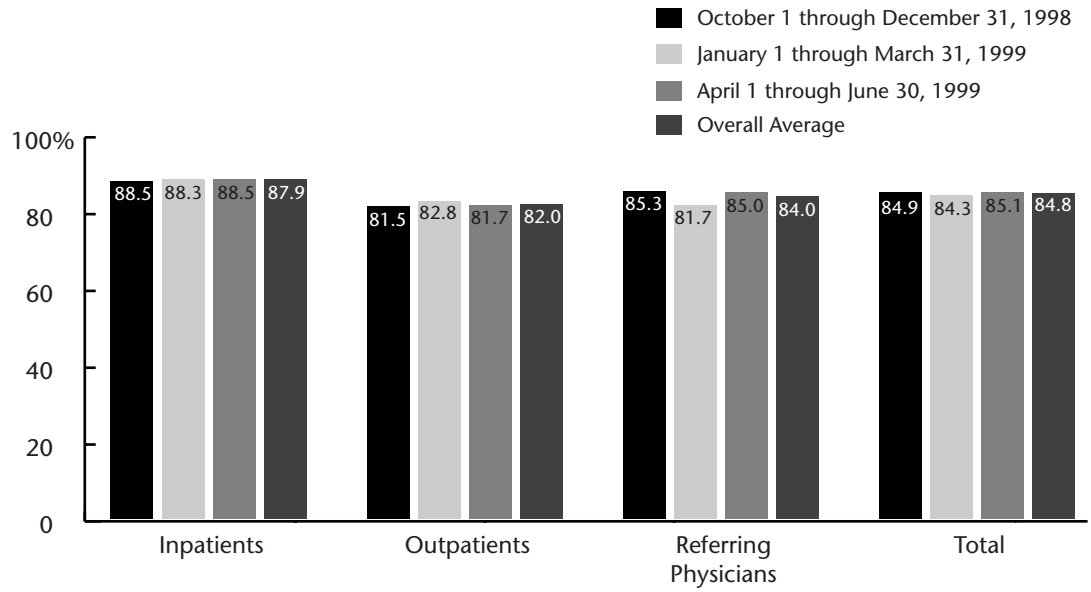
Based on the surveys described in the previous section, patients continue to report levels of satisfaction as high as those reported prior to the merger in patient satisfaction surveys conducted by UCSF and Stanford. Since the merger, USHC has undertaken quality improvement efforts to enhance and standardize the measurement of quality of care and service, including procedural outcomes and patient satisfaction. USHC's Quality Improvement Division includes the Outcomes Measurement Unit, which collects data on patient and referring physician satisfaction, patient complaints, health status, and telephone responsiveness through the use of standardized survey instruments. Once the survey results are collected, the Analytic Support Unit is charged with developing clinically meaningful information to be used for quality improvement and clinical outcome measurement purposes.

In the satisfaction surveys, the respondents rated areas such as physician and staff concern for patient comfort and questions, response to patient concerns and complaints, promptness of response to inpatient requests, and likelihood of choosing USHC for future medical care. Based on reports summarizing the nearly

25,000 surveys, patients and referring physicians have a high level of satisfaction with the quality of care provided by USHC. As presented in Figure 4, approximately 85 percent of patients and referring physicians combined stated that they were satisfied with USHC. An average of 88 percent of inpatients were satisfied overall with their hospital experience, while, on average, 82 percent of outpatients rated the hospitals satisfactorily. Lastly, 84 percent of referring physicians were satisfied with the treatment that their patients received at USHC.

FIGURE 4

Average Overall Patient and Referring Physician Satisfaction



Source: UCSF Stanford Health Care, "Patient and Referring Physician Satisfaction Survey Results." Document prepared by USHC's Office of Outcomes Measurement—Division of Quality Improvement.

Throughout the survey period, USHC patients and referring physicians maintained a steady level of satisfaction. Specifically, inpatients and outpatients surveyed remained at average satisfaction levels of 88 percent and 82 percent, respectively, over the nine-month period. Additionally, referring physicians reported a relatively constant satisfaction level of 84 percent. In general, inpatients are more satisfied with the quality of care they receive than are outpatients or referring physicians. However, all users appear to be relatively satisfied with USHC's quality of care.

Surveyed Satisfaction Levels Also Ranked High Prior to the Merger

Preceding the merger, UCSF and Stanford distributed separate patient satisfaction surveys to measure overall satisfaction with the level of care provided. However, these surveys used different questions, presentations, and participant selection methods. Although patients appeared satisfied previously as well, we cannot compare pre-merger to post-merger survey results.

Between July and October 1997, UCSF surveyed inpatients only, to determine their satisfaction with hospital quality of care. About 590 patients responded to the survey, a 41 percent response rate. The results showed that 88 percent of the patients rated the hospital's care as good to excellent. Close to half of these patients thought the care they received was excellent. Additionally, nearly 89 percent of inpatients receiving care from Mount Zion Hospital rated the quality of care as good to excellent.

During the period of September to November 1997, Stanford also surveyed its inpatients to discover their satisfaction with care. Stanford received approximately 140 responses, a 19 percent response rate. Each patient was asked to rate his or her satisfaction with the care received at the hospital, laboratory service provided by the hospital, and level of patient input concerning medical treatment. Further, based on overall satisfaction, Stanford asked its patients to rate the likelihood of recommending the hospital to others. Approximately 82 percent of the patients who responded were satisfied with the care they received.

USHC Is in the Process of Tracking Other Quality Indicators

Besides the patient satisfaction surveys, USHC has put mechanisms in place to monitor quality of care along a range of dimensions including mortality, readmission rates, patients' length of stay, major complication rates, emergency department visits within seven days of discharge, medication errors, inpatient falls, and transfusion errors. According to the director of the Quality Improvement Division, none of these indicators were consistently tracked using standardized benchmarks prior to the merger. Thus, we cannot make any comparisons. The director also told us that other hospitals track similar indicators, but comparisons are very difficult because the data captured is inconsistent and no consensus exists on the appropriate

benchmarks that should be used to measure performance. As a result, we cannot compare USHC's performance with that of other hospitals.

UCSF and Stanford Are Ranked High in Certain Specialties

In addition to USHC's internal indicators of quality care, U.S. News and World Report annually ranks America's best hospitals based on a national survey of hospitals. The survey considers such factors as hospital reputation among physicians, mortality rates, and annual surveys from the American Hospital Association. To be ranked on the list, a hospital has to be a member of the Council of Teaching Hospitals, be affiliated with a medical school, or possess a certain amount of medical technology. The best hospitals are ranked in descending order from 1 to 50.

Although both UCSF and Stanford were previously ranked in the top 10 U.S. hospitals overall, as of 1999, the hospitals are no longer ranked in this category. While the drop in ranking could relate to the various factors used by U.S. News and World Report as discussed above, the exact cause in unknown. However, when we reviewed the hospitals' current ranking in individual specialties, we found that UCSF ranked in the top 10 for its psychiatry and urology specialties. Stanford also ranked in the top 10 for its cardiology and heart surgery and urology specialties. Table 9 shows rankings of similar specialties that both UCSF and Stanford provide.

TABLE 9

Ranking of Similar Specialties Provided by UCSF and Stanford

Specialty	UCSF	Stanford
Cardiology and heart surgery	16	9
Geriatrics	16	36
Orthopedics	19	45
Pediatrics	16	15
Psychiatry	9	13
Urology	10	7

Source: U.S. News and World Report "America's Best Hospitals," July 19, 1999.

In addition to the specialties listed in the table, UCSF ranked in the top 10 in its digestive tract, eye, and neurology and neurosurgery specialties, and Stanford ranked in the top 25 for its cancer, gynecology, respiratory disorder, and rheumatology specialties.

USHC CONTINUES THE TRADITION OF COMMUNITY CARE

Both UCSF and Stanford appear to have committed roles in providing charitable services to low-income populations and the community as a whole. In its mission statement, UCSF stated its goal to provide "healing grounded in learning, and supported by acts of personal kindness." Like UCSF, Stanford considers its involvement in the local community essential to its success and works with outreach committees to develop an annual community benefit plan with input from the general public.

When USHC was formed, its mission was "to care, to educate, and to discover" for the benefit of all patients and the larger community. According to USHC, its community service role includes care for low-income and vulnerable populations provided by medical staff that "have specialized capabilities to care for adults and children who are gravely ill or in need of highly specialized services." Even if USHC changes the way that "it delivers health care, it must continue to fulfill these missions." Further, as part of its mission, it emphasized its intent to maintain services to low-income and indigent populations at levels similar to those prior to the merger.

Charity and Indigent Care Programs Vary

Both before and after the merger, most charitable expenses were spent on treating Medi-Cal patients.

Continuing with pre-merger traditions, USHC provides community services, such as health screenings, support programs for the elderly and disabled, and medical research, to persons who cannot afford health care because of inadequate resources or who are uninsured or underinsured. Covering a broad spectrum, these community activities are aimed at meeting the needs of low-income and vulnerable populations as well as the broader community.

Some of USHC's community services are designed to benefit specific populations such as Medi-Cal patients. Because Medi-Cal reimbursements do not cover the full cost of care, the remainder is considered by the hospital to be charity. Both before and after

the merger, most charitable expenses were spent on the treatment of Medi-Cal patients. Before the merger, UCSF and Stanford collectively spent $67 million on care for this population compared to the $80 million USHC spent in the first year after the merger. Based on hospital data collected by OSHPD, USHC delivered health care to 16 percent of the Medi-Cal population in the Bay Area after the merger, and the same hospitals served 18 percent[2] of Medi-Cal patients before the merger. Moreover, although its children's hospital served almost 5 percent of the Medi-Cal patients in San Mateo and Santa Clara counties prior to the merger, it now serves 8 percent of this population.

USHC now ranks as the third largest indigent care provider in the Bay Area.

The hospitals also provide services to the indigent population. Although neither UCSF nor Stanford was the largest indigent care provider in the Bay Area before the merger, UCSF was among the top 10 providers in surrounding Bay Area counties, including San Francisco, San Mateo, and Santa Clara. Specifically, UCSF held 19.2 percent of the market of indigent care in San Francisco County. Although Stanford was not a large indigent care provider in the past, it did serve some of this population at no cost. According to the most recent data available in June 1998, USHC now ranks as the third largest indigent care provider in the Bay Area. Moreover, since the merger, its UCSF hospitals rank as the second largest indigent care provider in San Francisco County, and its Stanford hospitals rank as the third largest indigent care provider in San Mateo and Santa Clara counties.

USHC also indicates that it provides services to vulnerable populations and the general public, including specialized clinics for those with diabetes, AIDS, and transplant problems. It also organizes annual food drives and operates a health library. All members of the surrounding communities benefit directly or indirectly from programs such as local health fairs and well-being support groups. Other benefits to the entire community include free transportation services, free primary care clinics, and monetary donations to local organizations.

Besides the quantifiable cost of the services described above, USHC provides additional benefits to the community through its advocacy of community service by employees. Specifically, several USHC employees serve on the boards of numerous

[2] This percentage is the average market share of UCSF and Stanford for Medi-Cal and indigent care in the Bay Area, during calendar years 1995 and 1996.

organizations, have memberships in associations, and participate in many other activities. USHC also solicits the assistance of other health care professionals to provide their services at no charge through participation in various community seminars and training programs. Other programs and services provided by USHC volunteers are the lifeline emergency system for the elderly, HIV testing, phone resource lines, radio health programs, and chaplain programs.

USHC Spends More on Community Services Than Before the Merger

Like UCSF and Stanford, USHC continues to provide charity services at little or no cost. For our comparison between pre-merger and post-merger amounts spent on charity, we used the most recent audited financial statements for the hospitals. Stanford's pre-merger expenses were for the 12 months ended August 31, 1997, and UCSF's expenses were for the 12 months ended June 30, 1997. However, USHC's post-merger expenses represent only the first 10 months of the merger ending August 31, 1998. To make the amounts somewhat comparable, we assumed that they were spent evenly over the audited period and annualized the USHC figures.

USHC spent 23 percent more on charitable activities than UCSF and Stanford combined before the merger.

As shown in Table 10, USHC spent over $20 million more on charitable activities than UCSF and Stanford did before the hospital merger. While UCSF and Stanford spent $46 million and $43 million, respectively, on charitable programs, for a total of $89 million, USHC spent approximately $110 million, an increase of almost 23 percent. Because its second year of operation ends on August 31, 1999, we could not review the amount it spent on charitable causes during this second year of operation. However, we have no basis to believe that it has reduced its level of spending on community programs.

TABLE 10

Comparison of Amounts Spent on Community Care, Pre-Merger Versus Post-Merger (Amounts in Millions)

	Pre-Merger			Post-Merger		
	UCSF*	Stanford†	UCSF/ Stanford	USHC‡	Dollar Variance§	% Change**
Benefits for low-income populations:						
Charity care††	$10.1	$ 2.0	$12.1	$ 2.7		
Unpaid costs of public program: Medi-Cal	36.0	31.5	67.5	80.1		
Unbilled services for low-income population	-	.1	.1	.3		
Cash and in-kind donations	-	.1	.1	.2		
Benefits for the broader community:						
Unbilled services for the community	-	1.6	1.6	1.8		
Education and research	-	5.1	5.1	19.2		
Other community services‡‡	-	2.9	2.9	5.6		
Total spent on community benefits§§	**$46.1**	**$43.3**	**$89.4**	**$109.9**	**$20.5**	**22.9%**

* Source: UCSF audited financial statements for the year ending June 30, 1997.

† Source: Stanford Health Services audited financial statements for the year ending August 31, 1997, notes to consolidated financial statements, footnote 4.

‡ Source: USHC audited financial statements for the 10 months ending August 31, 1998. These amounts are adjusted to reflect a 12-month period to allow for comparability of amounts before and after the merger.

§ Calculated by subtracting the pre-merger amounts from the post-merger amounts.

** Calculated by dividing the dollar variance by the pre-merger amount.

†† The UCSF statements did not separate charity care between benefits to low-income population and benefits to the broader community. For purposes of this table, we placed the entire amount under benefits for low-income population.

‡‡ This category includes services such as transportation and primary care clinics that are offered because of a need in the community.

§§ All expenses are shown net of any offsetting revenue from patients, donations, and other sources.

Table 11 shows USHC spent 7.4 percent of its net patient revenue on charity care during its first year of operation, and the two separate entities used 7.7 percent of their patient revenue for this purpose prior to the merger. Excluding other community benefits, hospitals in California typically spend approximately 1.3 percent of their net patient revenues on charity care. Some of the difference may be attributable to inconsistencies in reporting of various charity and community care categories and the inclusion of unpaid Medi-Cal costs.

TABLE 11

Comparison of Community Benefits as a Percent of Net Patient Revenue, Pre-Merger Versus Post-Merger (Amounts in Millions)

	Pre-Merger UCSF*/ Stanford†	Post-Merger USHC‡
Total spent on community benefits	$ 89.4	$ 109.9
Net patient revenue	1,157.1	1,489.2
Total community benefits expense as a percentage of net patient revenue	7.7%	7.4%

* Source: UCSF audited financial statements for the year ending June 30, 1997.

† Source: Stanford Health Services audited financial statements for the year ending August 31, 1997.

‡ Source: USHC audited financial statements for the 10 months ending August 31, 1998. These amounts are adjusted to reflect a 12-month period to allow for comparability of amounts before and after the merger.

CONCLUSION

USHC appears committed to carrying on the tradition of providing quality care and ensuring patient access to that care, just as UCSF and Stanford did before the merger. Furthermore, it continues to show concern for the community by providing valuable programs for low-income and vulnerable populations. Although the merger may have failed to realize the expected medical advances and financial benefits, USHC has achieved some limited success in maintaining quality patient and community care. However, to the extent that USHC cannot turn around its medical and financial outlook, patient access to quality care, as well as continued community benefits, may be affected in the future.

We conducted this review under the authority vested in the California State Auditor by Section 8543 et seq. of the California Government Code and according to generally accepted government auditing standards. We limited our review to those areas specified in the audit scope section of this report.

Respectfully submitted,

KURT R. SJOBERG
State Auditor

Date: August 31, 1999

Staff: Philip J. Jelicich, CPA, Deputy State Auditor
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APPENDIX A

Although the Merger Resulted in a Loss the First Two Years, It May Be Profitable in the Future

In Chapter 1, we identify many factors that have and will continue to contribute to the financial difficulties experienced by UCSF Stanford Health Care (USHC). These factors include failure to fully consolidate clinical programs and increases in costs that were underestimated or not considered at the time of the merger. To improve its financial performance, USHC assigned its consultants, The Hunter Group, to work on this task. The consultants identified expense savings of $170 million in its "Comprehensive Performance Improvement Plan" (recovery plan). With these expense savings, the consultants estimate USHC will break even in fiscal year 1999-2000. However, the savings alone are not sufficient for USHC to sustain a break-even position in the future. To identify additional opportunities for improvement beyond 2000, the consultants developed an inventory of additional opportunities for approximately $100 million in performance improvements to be realized by August 2001.

To analyze the effects of the merger on USHC's financial position, we attempted to separate revenue and expenses into two categories—those that may have occurred had University of California, San Francisco Medical Center (UCSF) and Stanford Health Services (Stanford) not merged and those that were a result of the merger. This separation is somewhat subjective and requires certain judgments and estimates to be made. In many areas, it is not possible to be precise. As a result, we made numerous judgments where we attempted to have errors in estimates offset each other. While not precise, we believe our calculations provide reasonable context for the approximate results of operations related to activities of the merger and activities not related to the merger.

Some of our allocations were generous to merger related operations and others were not. For instance, we used USHC's analysis of diagnostic related groups (defined in Chapter 1, footnote 7) that resulted in a more conservative definition of highly

specialized cases as discussed in Chapter 1. As a result, we may have allocated too little revenue to merger operations. On the other hand, we allocated to the merger all of the revenue from additional highly specialized cases even though we believe UCSF and Stanford may have been able to increase this revenue by some amount without merging. Thus, we may have allocated too much revenue to merger operations. Any errors in estimates in these two calculations would counter balance each other.

On the expense side, we did not allocate to the merger any expense savings implemented in 1999 from the recovery plan even though staff reductions have begun. However, we allocated to the merger savings from reductions in administrative areas, resulting primarily from consolidating activities, even though some operating efficiency may have been achievable without the merger. Again, any errors in estimates in these allocations would counter balance each other.

WITH INTERVENTIONS, USHC PROJECTS A MERE $1 MILLION PROFIT FROM ITS FIRST FOUR YEARS OF OPERATIONS

In its pre-merger business plan, USHC in coordination with Ernst & Young estimated that the merger of UCSF and Stanford would generate a total $171 million profit in its first four years of operation—$51 million from activities not attributed to the merger and $120 million from merger activities. However, based on its audited financial statements for fiscal year 1997-98 and recent projections of the consultants, USHC estimates that it will realize a gain of only $1 million over the same period, assuming full achievement of $270 million of performance improvement goals—a shortfall of $170 million from original expectations. Table 12 illustrates estimated and actual/projected results of operation. Based on our allocations between activities that UCSF and Stanford would have performed had they remained separate and those activities that occurred because of the merger, the entire shortfall is due to activities not related to the merger, which UCSF and Stanford would have realized had they not merged.

TABLE 12

Comparison of Financial Expectations With Actual Results for the Four Years Ending August 31, 2001 (Amount in Millions)

	Expected	Actual/ Projected	Variance (Shortfall)/Gain
Combined profit/ loss not attributed to merger	**$51.3**	**$(119.3)**	**$(170.6)**
Effects of merger:			
Additional profit from increased volume	84.8	130.5	45.7
Cost savings	110.5	130.5	20.0
Cost of merger	(75.0)	(140.4)	(65.4)
Net profit/loss from merger	**120.3**	**120.6**	**0.3**
Total profit/loss as merged entity	**$171.6**	**$1.3**	**$(170.3)**

Although the projected four-year profits of more than $120 million from merger activities are approximately equal to the amount expected in the pre-merger business plan, the gain of $300,000 is completely dependent on USHC implementing both the recovery plan and the inventory of additional opportunities of the consultants.

To review the merger-related operations, we completed a separate analysis of the first two years of operation ending August 31, 1999, and another analysis of the next two years of operation ending August 31, 2001. In the first two years, the costs of the merger exceeded the revenue and cost savings resulting from the merged operations. However, in the next two years, revenue and cost savings should far outweigh the costs of the merger, resulting in a gain that UCSF and Stanford would not realize if they had not merged.

The First Two Years of the Merger Will Not Be as Profitable as Expected

Although the pre-merger business plan projected a profit of $65 million for the first two years of operation, USHC is now expecting a two-year loss of $46 million—a shortfall of

$111 million, as shown in Table 13. Based on our analysis, $59 million of the shortfall results from merger activities. The remaining $52 million of the shortfall would have resulted even if UCSF and Stanford had not merged.

TABLE 13

Comparison of Financial Expectations With Actual Results for the 22 Months Ending August 31, 1999 (Amount in Millions)

	Expected	Actual/ Projected	Variance (Shortfall)/Gain
Combined profit/ loss not attributed to merger	**$25.0**	**$(26.6)**	**$(51.6)**
Effects of merger:			
Additional profit from increased volume	34.1	42.7	8.6
Cost savings	41.9	17.0	(24.9)
Cost of merger	(36.0)	(78.9)	(42.9)
Net profit/loss from merger	**40.0**	**(19.2)**	**(59.2)**
Total profit/loss as merged entity	**$65.0**	**$(45.8)**	**$(110.8)**

The $52 million shortfall resulted from factors that were either not fully considered or were not expected in the pre-merger business plan as we discussed in Chapter 1. These include the following:

- Deteriorating payment rates resulting in decreased revenue of $79 million.
- Staffing increases for expanded services of $53 million related to both an increase in the number of patients and increased staff to patient ratio.
- Higher costs for supplies of $35 million.
- Unexpectedly high costs related to information technology of $36 million.

The $59 million shortfall related to the merger exists because the $9 million increase in revenue was not sufficient to cover the $25 million shortfall in cost savings and increased costs of

$43 million that were not expected in the pre-merger business plan. The underestimated costs of the merger include $10 million of administrative staffing, $11 million in paid time off expenses related to a difference in accounting for this expense at UCSF prior to the merger, $10 million in one-time costs related to collection efforts, and $12 million in other costs.

USHC Will Not Earn the Extent of Gains Initially Projected Despite Extreme Cost Savings During the Next Two Fiscal Years

Although the pre-merger business plan projected a profit of $107 million for the second two years of operation, the latest estimate from the consultants predicts a mere $47 million profit, a difference of $60 million. The consultants base this prediction on the premise that USHC implements all elements of the recovery plan and the inventory of additional opportunities. As described more fully in Table 14, based on our allocations, we estimate that without the merger UCSF and Stanford would have realized a bigger shortfall, approximately $119 million. Further, the earlier shortfall that resulted from merger-related activities during USHC's first two fiscal years of operation will be reversed in the future, assuming USHC implements all of the consultants' recommendations.

TABLE 14

Comparison of Financial Expectations With Actual Results For the Two Years Ending August 31, 2001 (Amount in Millions)

	Expected	Projected	Variance (Shortfall)/Gain
Combined profit/ loss not attributed to merger	**$26.3**	**$(92.7)**	**$(119.0)**
Effects of merger:			
Additional profit from increased volume	50.7	87.8	37.1
Cost savings	68.6	113.5	44.9
Cost of merger	(39.0)	(61.5)	(22.5)
Net profit/loss from merger	**$80.3**	**$139.8**	**$59.5**
Total profit/loss as merged entity	**$106.6**	**$47.1**	**$(59.5)**

The $119 million shortfall from activities not related to the merger exists because profit not anticipated in the pre-merger business plan, generally due to an increase in less specialized cases, may not be sufficient to cover the costs of factors discussed in Chapter 1 such as:

- Deteriorating payment rates resulting in decreased revenue of $123 million.
- Staffing increases for expanded services of $58 million.
- Higher costs for supplies of $38 million.
- Depreciation costs of $36 million on unanticipated upgrades to information technology.

The consultants' two plans include implementing some cost savings in 2000 and realizing the full benefits of $270 million annually by 2001. The two plans combined contain cost savings over this second two-year period of over $376 million, of which we estimate $273 million do not relate to the merger. These include $109 million in salary reductions, $49 million in estimated supply reduction, and $41 million in other expense reductions. To some extent, the salary and supply reductions are intended to offset the unexpected increases that occurred in these areas. The remaining $74 million in savings that do not relate to the merger are the result of opportunities identified by the consultants.

The gain of $59 million related to the merger results from revenue and cost savings that exceed the increased costs of the merger not expected in the pre-merger business plan. In the next two fiscal years, we estimate that USHC will have $37 million in more revenue from the merger than estimated in the pre-merger business plan. In addition to revenue from highly complex cases, one of the factors for the increase in revenues was that USHC estimates that it was able to negotiate a higher reimbursement rate for its contracts due to the merger.

The additional cost savings from the merger are primarily the result of implementing the consultants' recovery plan recommendations. For example, although the pre-merger business plan estimated annual cost savings in the finance area of approximately $1 million, the recovery plan calls for over $40 million in savings over the next two years of operation.

However, the costs of merger in the next two-year period will exceed the pre-merger plan estimate by $23 million primarily due to the unexpected paid time-off costs of $13 million. We discuss these costs more fully in Chapter 1.

The Merger May Begin to Realize Financial Benefits in the Future

Based on our analysis, UCSF and Stanford would have lost a combined $93 million over the next two years had they not merged. The magnitude of this estimated loss is dependent on whether expense savings from the consultants' recovery plan and inventory of opportunities are realized and the fact that we believe most of these savings could have been realized without the merger. Had we not attributed the cost savings in this way, the outlook for UCSF and Stanford not merging would be even worse.

Conversely, based on our analysis, we estimate that USHC will realize a $140 million profit related to merger operations over the next two years. In addition to attributing certain amounts of additional revenue to the merger, cost reductions achieved primarily through consolidation of administrative activities made possible by the merger will exceed the ongoing cost of merging. However, this estimate is also dependent on USHC's full implementation of cost reductions outlined by the consultants that are scheduled to occur by August 2001.

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APPENDIX B

UCSF Stanford Health Care Continues to Face Challenges in the Health Care Market

This appendix discusses the changes that have occurred in the health care market over the two years since the merger. Specifically, we focus on managed care, consolidations of health care purchasers and providers, and demand for hospital services. To identify changes that have been both favorable and unfavorable to UCSF Stanford Health Care (USHC) and other Bay Area[1] hospitals, our health care consultant conducted market research and reviewed hospital data compiled by the Office of Statewide Health Planning and Development (OSHPD). Some of this data was only available through December 1998.

In addition, this appendix identifies changes between the operating and financial performance of the University of California, San Francisco Medical Center (UCSF) and Stanford Health Services (Stanford) before the merger and the hospitals' performance after the merger. Specifically, we focus on areas such as average length of stay, net inpatient revenue per payor, and operating expense per patient discharge. Again, we used data reported to OSHPD. As benchmarks, we also compared UCSF and Stanford to other University of California hospitals,[2] other university hospitals,[3] large nonuniversity hospitals, and all acute-care hospitals in the surrounding 10-county area.[4]

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[1] As used in this appendix, the Bay Area includes the counties of San Francisco, San Mateo, and Santa Clara.

[2] Other University of California hospitals include the four following hospitals: University of California, Davis Medical Center; University of California, Los Angeles Medical Center; University of California, Irvine Medical Center; and University of California, San Diego University Hospital.

[3] Other university hospitals include the four University of California hospitals listed in Footnote 1, Loma Linda University Medical Center and Los Angeles County/University of Southern California Medical Center.

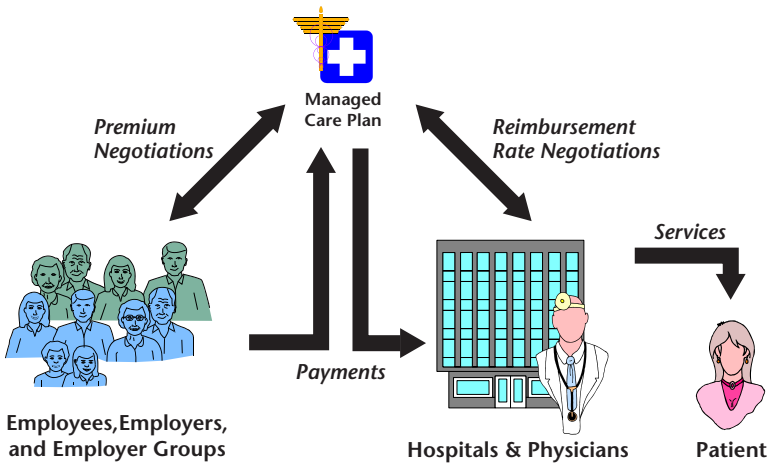
[4] All acute-care hospitals report operating statistics to OSHPD. "Comparable" facilities also report financial data to OSHPD, while certain "noncomparable" hospitals, primarily Kaiser facilities, do not report financial results. Data for 1991 through 1995 in the accompanying graphs are from annual reports for OSHPD reporting years 1991-1992 through 1995-1996. Data for 1996 are from quarterly reports for the period July 1995 through June 1996. Data for 1997 are annualized estimates based on the three-quarter period July 1996 through March 1997. According to OSHPD, quarterly data may be subject to revision in the annual reports. Therefore, data shown for 1996 and 1997 should be considered preliminary.

MANAGED CARE PRESENCE IN THE BAY AREA

Over the last few years, the health care industry has changed substantially as it evolved from a health insurance, or indemnity, environment to managed care in an effort to contain ever-increasing costs that rose faster than the inflation rate. The result is a series of complicated relationships among a variety of health care plans, employers, employer purchasing groups, providers of medical services, and consumers. The interactions are rather confusing, so we have diagramed the relationships typical in managed care and the corresponding flow of activity in Figure 5.

FIGURE 5

Flow of Activity Involving Managed Care Plans



HMO Market Share and Enrollee Mix

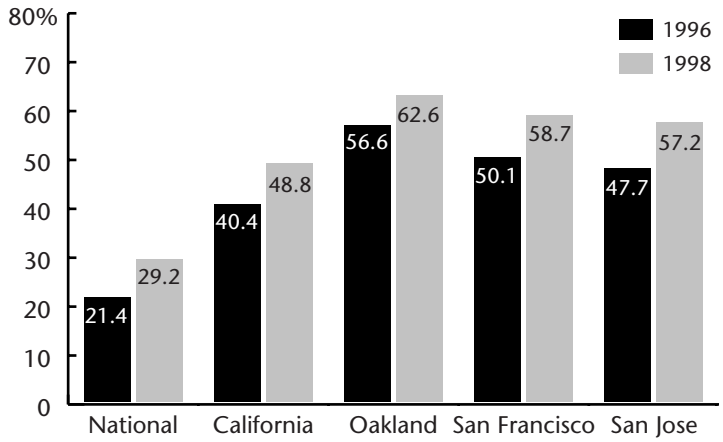
Over the past two years, health maintenance organizations (HMOs)[5] have continued to increase their penetration. As shown in Figure 6, their market share has risen to 29 percent nationally, up from 21 percent in 1996. The portion of the population covered by HMOs in California and the Bay Area specifically has also increased and continues to be well above the national average. As of July 1998, they served 49 percent of the total population in California, up from 40 percent in 1996.

[5] A health maintenance organization, or HMO, is a managed care plan that offers a comprehensive set of health services. The enrollee bears very low co-payments when obtaining medical care from network providers but has almost no coverage for any services from providers outside the HMO.

In much of the Bay Area, the HMO share is even higher, at 59 percent in San Francisco (up from 50 percent) and at 57 percent in San Jose (up from 48 percent).

FIGURE 6

HMO Share of Population



Source: Interstudy, June 1997 and 1999.

The mix of HMO enrollees in the Bay Area (commercial, Medicare and Medi-Cal, etc.)[6] has been relatively stable since 1996. The HMOs have been most successful at signing up commercial enrollees in Oakland, with enrollment approaching 100 percent of the relevant population. The HMO share of Medicare enrollees has remained at slightly over one-third. Although they had been aggressively pursuing Medicare enrollees because of relatively high fixed-payments in the Bay Area, the Federal Balanced Budget Act (act) of 1997[7] changed the way payments to doctors, hospitals, and HMOs are calculated. Specifically, the act capped Medicare payments to HMOs at an increase of only 2 percent annually until 2003, down from increases of 5 percent to 10 percent in previous years.[8]

[6] Commercial enrollees include those who receive care from an HMO, PPO, or other form of planned care provider through their employers. Medicare enrollees are supported under Medicare, a third-party reimbursement program administered by the Social Security Administration that underwrites the medical costs of persons 65 and over. Medi-Cal enrollees are supported under Medi-Cal, a federally aided state-operated Medicaid program that provides medical benefits to low-income persons.

[7] An act that reduced Medicare and Medicaid spending.

[8] John D. Cochrane, "NewsFront," *Integrated Healthcare Report*, November 1997, p. 17; December 1998-January 1999, p. 4.

Medi-Cal cost containment efforts to shift enrollees to managed care are proceeding on a county-by-county basis and have increased that share of the market. By February 1999, the number of Medi-Cal enrollees in HMOs or managed care plans had increased by almost 40 percent over February 1998.[9] Nevertheless, the overall share remains quite low, ranging from 1.7 percent in San Francisco to 5.5 percent in Oakland.

HMO Consolidation

Managed care plans, particularly HMOs, penetrated the health care services market in the Bay Area during the 1990s to a depth that caused structural changes in its delivery system. HMOs, competing with one another for a larger share of the market, have kept medical insurance premiums low by more closely managing the use of physician and hospital services, lowering payments to health care providers, and consolidating with one another to cut costs. Although one managed care plan, Kaiser Foundation Health Plans, Inc., continues to dominate HMO coverage in the Bay Area, its share has declined slightly since 1996. Vigorous competition and consolidation among surviving HMOs continues. Nationwide, nearly 200 mergers occurred between 1987 and 1997.[10] The July 1999 acquisition of Prudential Health Care by Aetna, which will affect the California marketplace, is the most recent example of consolidation within the industry.

These consolidations leave managed care enrollees with fewer choices for health care coverage. For example, in their September 1997 open enrollment period, members of the California Public Employees Retirement System (CalPERS) had only 10 HMOs to choose from, down from 14 in 1996. Statewide, just four HMOs accounted for over 75 percent of enrollees.[11] In the Bay Area, as of July 1998, the major providers are Kaiser, Health Net, Pacific Care, Aetna, Blue Cross (CaliforniaCare), and Lifeguard.

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[9] California Medical Assistance Program, Medi-Cal Report website, www.dhs.cahwnet.gov/org/admin/ffdmd/mcss

[10] *Integrated Healthcare Report*, September 1998, p. 2.

[11] *Integrated Healthcare Report*, April 1998, p. 2.

HMO Pricing

The major providers, or dominant HMOs, serve as powerhouses in their area and receive certain concessions that others are not afforded. Their size allows them more room to negotiate with hospitals such as USHC than smaller providers and plans can expect. However, because of their size, even within the areas they serve, major providers may feel competition from other dominant HMOs. As a result, the dominant HMOs in California continue to engage in fierce price competition to win managed care contracts. Historically, HMOs have competed by offering low premiums to increase the volume of enrollees while controlling costs through practicing effective hospital utilization and extracting price concessions from health care providers.

Large employee purchasing groups, such as CalPERS and Pacific Business Group on Health, have also been instrumental in keeping down HMO premiums. Between 1995 and 1998, the Pacific Business Group on Health was able to reduce premiums by 12.8 percent for its members, while CalPERS negotiated premiums that fell 5.8 percent over the same period.[12]

Shift in Balance of Power

However, within the last two years, the balance of power among HMOs, employer-purchasing groups, and health care providers has shifted. HMO enrollment growth has slowed slightly from a peak rate of 15.8 percent in 1996 to 14.7 percent in 1998. Although their volume and revenues are higher, profits are down as a result of costs rising at a rate of 7 percent to 10 percent annually. In 1997, Kaiser suffered its first annual deficit—$266 million on revenue of $14.5 billion—followed by an additional loss in 1998 of $288 million.[13]

Although successful in keeping premiums low in the past, employer purchasing groups recently have had to agree to increases. For instance, in negotiations between Kaiser and CalPERS, Kaiser asked for 12 percent and CalPERS agreed to a

[12] *Integrated Healthcare Report*, December 1998-January 1999, p. 5.

[13] *Integrated Healthcare Report*, February 1999, p. 15.

10.7 percent premium increase for its enrollees for 1999 health benefits.[14] Across all of its HMOs, CalPERS has agreed to an average 9.7 percent increase in premiums for year 2000 health care benefits; the increase across all plans for 1999 benefits averaged 7.3 percent.[15] The fact that Kaiser extracted a higher premium increase may explain, at least in part, its loss of market share from 1996 to 1998.

Higher HMO costs result, in part, from increased provider resistance to payment cuts.[16] Negotiations between HMOs and health care providers have recently resulted in higher payment rates for health care services. In the first half of 1998, Sutter Hospital terminated negotiations with Blue Cross rather than accept the payment rate offered. The action was viewed by some as the "opening shot in an increasingly commonplace test of power."[17] Two other hospital systems, Catholic Healthcare West and Columbia/HCA, also threatened to cancel their contracts with Blue Cross unless the plan agreed to higher payments. All three hospital groups ultimately agreed to new contracts, and Sutter at least received an undisclosed increase in payments extending through the year 2000. Sutter's heavy concentration in Northern California may have weakened the negotiating position of Catholic Healthcare West and Columbia/HCA and contributed to this result.[18]

Consolidation Among Physician Groups

Medical groups dominate the provision of physician services to managed care patients in the Bay Area. Physicians outside of a large physician group[19] typically find it more difficult to gain access to managed care patients. In our prior report, our health care expert discussed the trend of consolidations among

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[14] *Integrated Healthcare Report*, July 1998, p. 3.

[15] *Integrated Healthcare Report*, May 1999, p. 19.

[16] *Integrated Healthcare Report*, December 1998-January 1999, pp. 2-4, 13.

[17] *Integrated Healthcare Report*, July 1998, p. 1.

[18] *Integrated Healthcare Report*, June 1998, pp. 14, 17; July 1998, pp. 1-2.

[19] A physician group is a group of individual physicians who have formed an affiliation that allows them to gain bargaining power and access to information systems and utilization-management techniques.

physician groups to improve their ability to obtain managed care contracts and identified seven major medical groups in the Bay Area.[20] We also noted that physician groups did not appear to be thriving financially.

Since then, three of the seven groups have experienced serious financial difficulties. For example, in July 1998, FPA Medical Management, a San Diego-based national independent practice association[21] with a significant presence in the Bay Area, filed for protection under bankruptcy laws. In another example, the Brown and Toland Medical Group reported a $4.5 million deficit in 1998 and was unable to pay medical fees owed to its physicians. Because USHC's university physicians were members of Brown and Toland, the merged entity agreed to reimburse $900,000 owed to them. In return, USHC received an undisclosed equity stake in Brown and Toland's Physician Services Organization that provides administrative services.

Another physician group identified as a key player in the Bay Area, MedPartners, also ran into financial problems in early 1999. Its California operations include Mullikin and several other physician groups it had acquired during the 1990s. In March 1999, the California Department of Corporations placed MedPartners in bankruptcy protection when it found that the plan owed hospitals and other providers at least $73 million.[22]

Hospital Systems Consolidation

Consolidation to gain leverage with large HMOs and physician groups has continued among hospitals. Nationally, 181 hospital consolidations occurred in 1997, up 7 percent from the year before.[23] In the Bay Area, Sutter acquired Oakland-Berkeley Summit Medical Center, the largest independent private hospital left in the area. The deal puts under Sutter control not only Summit and Berkeley's Alta Bates Medical Center but also the hospitalization of patients from the closure of Oakland's Kaiser hospital. Across the bay, Sutter's California Pacific Medical Center acquired San Francisco's 341-bed Ralph K. Davies Medical

[20] Hill Physicians Medical Group, BayCare Medical Group, Brown and Toland Medical Group, Palo Alto Medical Foundation, Santa Clara County Practice Association, FPA/AHI Healthcare Systems, and Mullikin/MedPartners.

[21] An independent practice association is an intermediary between physicians and managed care providers.

[22] *Los Angeles Times*, March 18, 1999, p. A1

[23] *Integrated Healthcare Report,* September 1998, p. 2.

Center, leaving Chinese Hospital and St. Luke's as the only remaining independents in San Francisco.[24] St. Luke's has tried and failed to align with various partners in recent years including Sutter, Catholic Healthcare West, and San Francisco General.[25] Even before these acquisitions, Sutter was the largest provider in the three-county Bay Area with 19 percent of annual admissions.[26] As well as enabling it to be a more formidable competitor for managed care contracts, the continuing buildup of resources available within the Sutter system reduces its need to refer patients to outside hospitals such as USHC.

DEMAND FOR HOSPITAL SERVICES

Demand for health care can be measured by the number of inpatient days, patient discharges, average length of stay, and occupancy rates that are driven in part by population trends. Based on average annual inpatient days, the trend generally flattened from 1991 to 1995 and has continued downward except for a slight increase between 1997 and 1998. When adjusted for population growth, however, the decline is more dramatic, and the 1998 increase disappears. For the 10-county area[27] surrounding USHC, inpatient days per 1,000 persons declined more than 11 percent from 1995 to 1998 for every county except San Francisco. In San Francisco, inpatient days rose almost 5 percent during that same period. Previously, average inpatient days per 1,000 persons remained virtually unchanged from year to year. Much of the decline seems to have been caused by a reduction in the average length of stay. In the same 10-county area, this reduction continued into 1998; however, for USHC as well as other large hospitals generally, average length of stay has increased over the past year.

Average Annual Inpatient Days

As shown in Figure 7, from 1991 through 1997, there has been decreasing demand for inpatient hospital services. UCSF has experienced the most impact from this trend with the number

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[24] *Integrated Healthcare Report,* February 1998, pp. 10, 18.

[25] Rauber, Chris, "Consolidation is King in San Francisco Market," *Modern Healthcare,* February 22, 1999, p. 76.

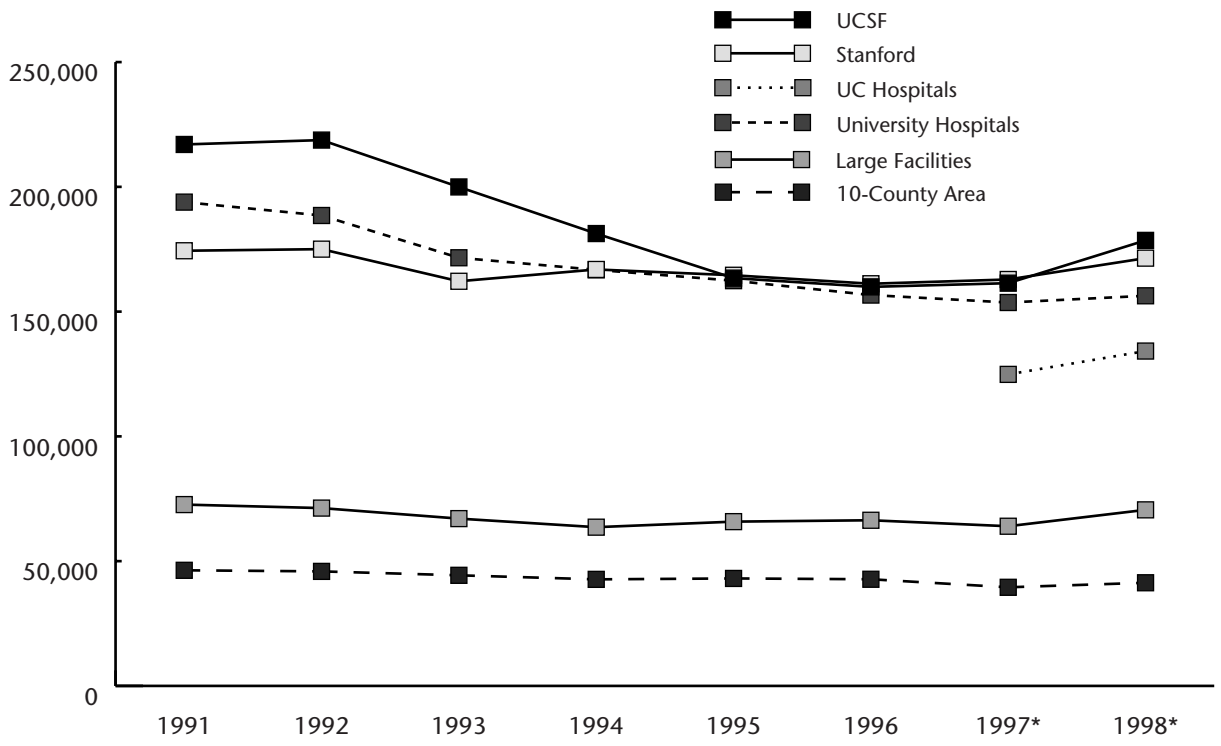
[26] Neil, Robert, "San Francisco's Leading Hospital Company Wants to Expand, but the FTC Isn't Convinced – Yet," *Medical Industry Today*, March 9, 1999.

[27] The 10-county area includes the counties of Alameda, Contra Costa, Marin, Napa, San Francisco, San Mateo, Santa Clara, Santa Cruz, Solano, and Sonoma.

of days falling from 217,000 in 1991 to 161,000 in 1997, a 26 percent reduction. The proportion of inpatient days by payor type for UCSF has declined for non-HMO Medicare and non-HMO Medi-Cal by 4 percent and 6 percent, respectively, from 1995 through 1998. Overall, the trend appears to end in 1998 for Bay Area hospitals where inpatient days increased by 2 percent to 10 percent over 1997 reported days. Both UCSF and large facilities' inpatient days increased by over 10 percent. Similarly, the increase in patient days for Stanford and the other University of California hospitals were 5 percent and 8 percent, respectively.

FIGURE 7

Average Annual Inpatient Days (1991 Through 1998)



Source: OSHPD Annual Hospital Disclosure Report and OSHPD quarterly data.

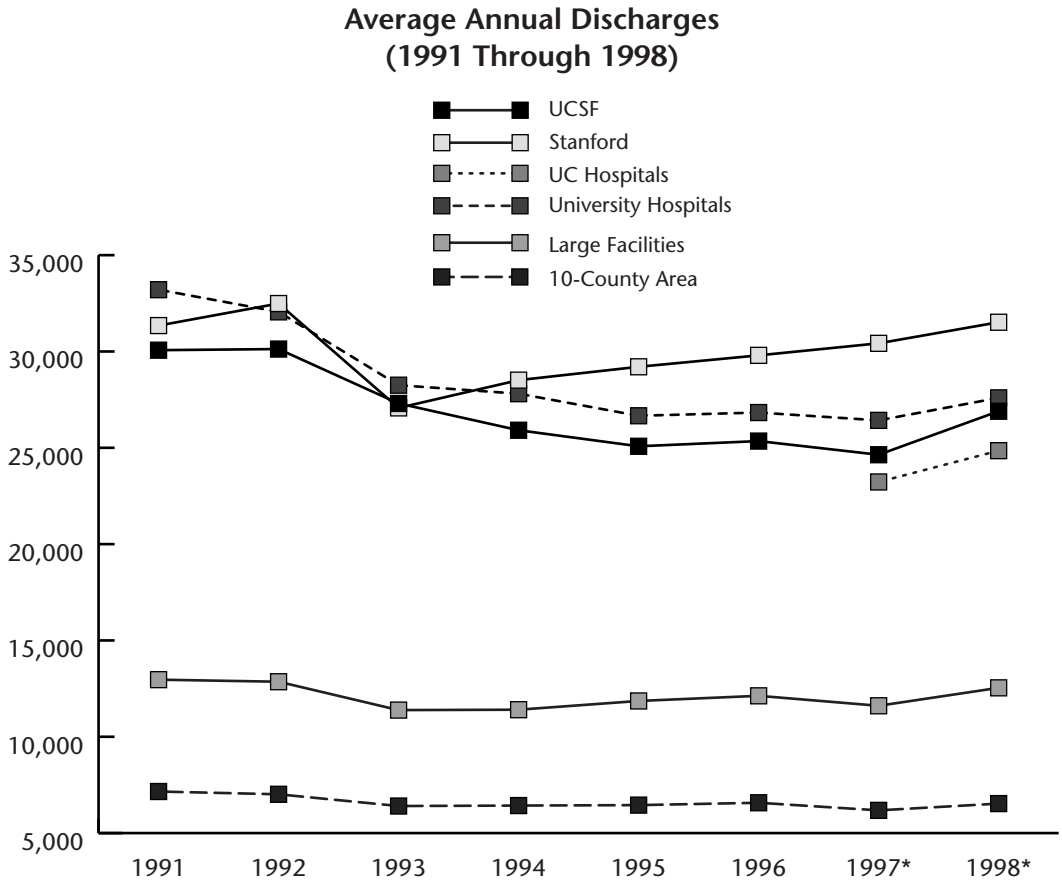
* 1997 through 1998 based on quarterly data with the exception of UCSF and Stanford. For these, 1998 values are annualized based on 10 months of data except for Lucile S. Packard Children's Hospital, which includes 12 months of data.

Average Annual Patient Discharges

Total inpatient days reported above are the product of the number of patient discharges (or admissions) and the average length of stay. When hospitals are compensated with a fixed fee

per case, as under Medicare's "diagnostic related groups"[28] system, the number of discharges and average length of stay are better indicators of performance than is the number of inpatient days. As shown in Figure 8, total discharges at Stanford exceeded total discharges at UCSF by 4,600, or 17 percent, in 1998. The total number of discharges at UCSF has declined 11 percent since 1992, though the rate of decline has slowed since 1994. In contrast to both UCSF and other university hospitals, total discharges at Stanford have increased 16 percent since 1993. After declining in 1992 and 1993, total discharges at all Bay Area hospitals remained relatively flat until 1998. From 1997 to 1998, total discharges for all Bay Area hospitals increased by 4 percent to 9 percent.

FIGURE 8



Source: OSHPD Annual Hospital Disclosure Report and OSHPD quarterly data.

* 1997 through 1998 based on quarterly data with the exception of UCSF and Stanford. For these, 1998 values are annualized based on 10 months of data except for Lucile S. Packard Children's Hospital, which includes 12 months of data.

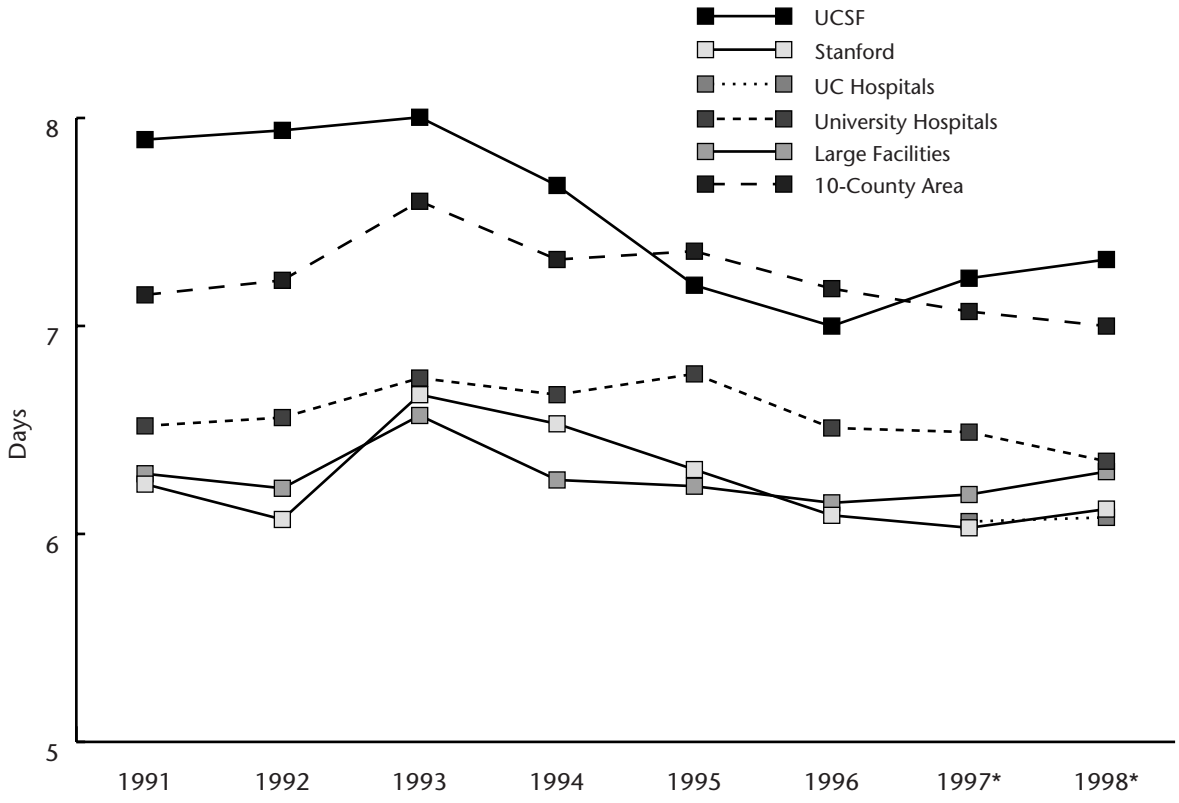
[28] This diagnostic related group system is explained in Chapter 1, Footnote 7.

Average Length of Stay

After increasing from 1991 through 1993, average lengths of stay have generally declined at Bay Area hospitals. As Figure 9 illustrates, UCSF showed a significant reduction between 1993 and 1996; however, the length of stay is now 6.6 days, a 9 percent increase over the 1996 average. Stanford has also shown significant, though less dramatic, reductions in the average length of stay since 1993. However, average lengths of stay may not be directly comparable across facilities due to differences in patient mix and the types of procedures performed at different hospitals. Even for a single institution, changes in the average length of stay may be the result of changes in patient mix over time rather than changes in the efficiency of hospital operations.

FIGURE 9

Average Length of Stay (1991 Through 1998)



Source: OSHPD Annual Hospital Disclosure Report and OSHPD quarterly data.

* 1997 through 1998 based on quarterly data with the exception of UCSF and Stanford. For these, 1998 values are annualized based on 10 months of data except for Lucile S. Packard Children's Hospital, which includes 12 months of data.

Occupancy Rates

Although occupancy rates on available beds declined generally in the 10-county area from 1991 through 1997, this trend was reversed in 1998. Occupancy rates for the 10-county area rose from just under 59 percent to over 61 percent. Occupancy rose from 70 percent to almost 72 percent at Stanford, while at UCSF, it rose from just under 67 percent in 1997 to over 74 percent in 1998. One factor contributing to this increase is a particularly severe flu season in 1998. The increase at UCSF was caused in part by its decision to keep its emergency room "off diversion," resulting in a larger number of admissions through that channel.

FINANCIAL PERFORMANCE INDICATORS

Capitation Payments and Revenue by Payor

Data on capitation and noncapitation payments to USHC hospitals from Medicare, Medi-Cal, and private payors indicate, not surprisingly, that noncapitation revenue per patient day is higher than capitation revenue for all three types of payors. Evidence also indicates that revenue per patient day increased from 1998 to 1999 for the capitation group covered by private payors. As the financial pressures on hospitals mount, capitation rates are becoming an increasingly important element of negotiations with insurers. The increase in revenue per patient day for capitation patients covered by private payors suggests that USHC may have been successful in increasing revenues from this source. [29]

For USHC as a whole, revenue per patient day (capitation and noncapitation combined) has increased for Medicare patients but has fallen for both Medi-Cal and private payors. Moreover, it appears that private payor revenues have deteriorated more at UCSF than at Stanford.

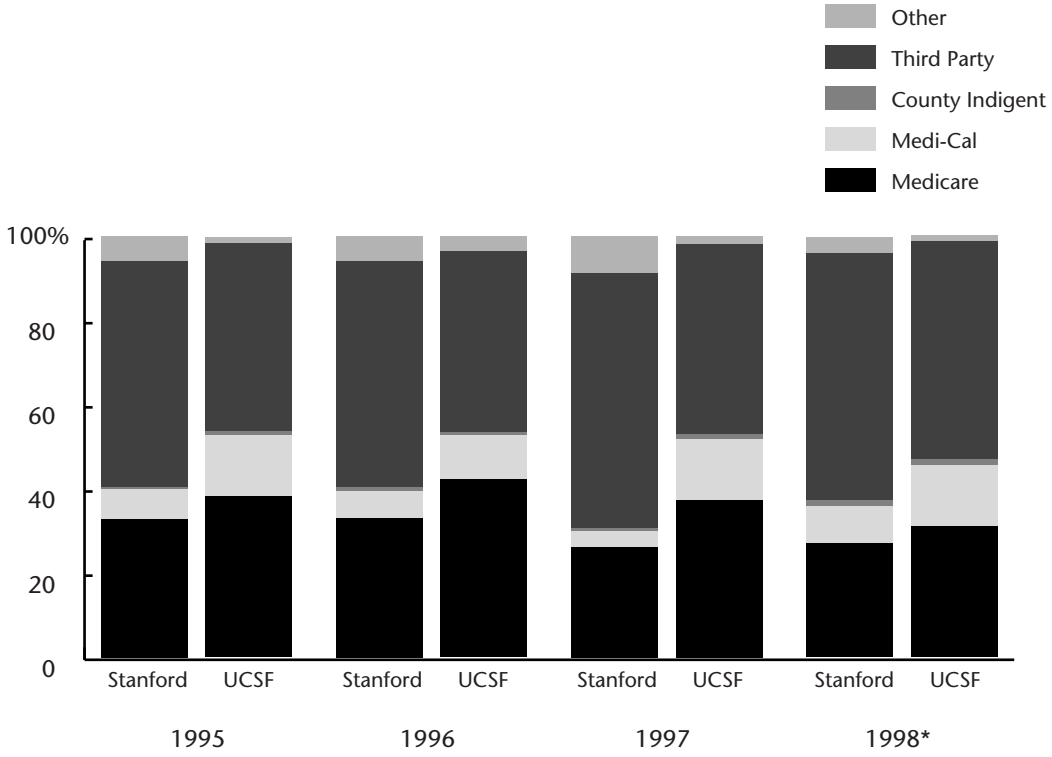
[29] Revenue per patient day is affected by capitation rates but also reflects other factors including average length of stay.

Net Inpatient Revenue by Payor Type

In general, Medicare and third-party payors are important sources of revenue to both UCSF and Stanford. As illustrated in Figure 10, Medicare represented 31 percent of UCSF's inpatient revenue and 27 percent of Stanford's in 1998. Since 1995, inpatient revenue from third-party payors has increased by 7 percent to account for over 50 percent of inpatient revenue in 1998 for both UCSF and Stanford.

FIGURE 10

Percent of Net Inpatient Revenue By Payor Type (1991 Through 1998)



Source: OSHPD Annual Hospital Disclosure Report and OSHPD quarterly data.

* 1998 values are annualized based on 10 months of data except for Lucile S. Packard Children's Hospital, which includes 12 months of data.

Total Operating Expense Per Discharge

Total operating expense per discharge across all Bay Area hospitals has been increasing since 1991. Although data for all the benchmarks were not available for 1997 and 1998, the remaining University of California hospitals and Stanford did not experience the significant increase that UCSF did in 1998. UCSF professional fees, which account for 21 percent of its total operating expense in 1998, increased by 66 percent after the merger. This increase is not primarily the result of growth in the rate of professional fees, but rather the inclusion of professional faculty practices subsequent to the merger. Despite the overall increase in expense per patient discharge for UCSF at 29 percent compared to an 8 percent increase for Stanford, UCSF spends 3 percent less per discharge than Stanford. The other University of California hospitals, whose operating expense increased by 3 percent in 1998, spend on average one-third less than UCSF and Stanford per discharge.

Agency's response provided as text only:

UCSF Stanford Health Care
300 Pasteur Drive
H3200, MC 5230
Stanford, CA 94305

August 25, 1999

Mr. Kurt R. Sjoberg
California State Auditor
Bureau of State Audits
555 Capitol Mall, Suite 300
Sacramento, California 95814

Dear Mr. Sjoberg:

On behalf of UCSF Stanford Health Care, I would like to thank you for the opportunity to respond to the report prepared for the Joint Legislative Audit Committee. We appreciate the hard work and tremendous effort you and your staff undertook to prepare this report, especially given the quantity and complexity of the documents we provided for your review and analysis.

We are in general agreement with your division of financial results into merger and non-merger impacts In particular, we note your conclusion that in the next two years, with the successful implementation of the cost reduction plan and other performance improvement efforts, UCSF Stanford Health Care may realize $140 million of financial benefits from the merger. This figure exceeds by 75% the $80 million target projected in the 1997 merger business plan. The $140 million merger gain more than offsets a loss of $93 million that your analysis says could occur absent the merger, netting $47 million of operating income overall for the next two years.

At the same time, the $93 million loss projected absent the merger demonstrates that the underlying health care environment in which we operate has deteriorated markedly, due to further reductions in government support, a highly competitive market for private health insurance, and rapidly rising costs for new drugs, medical technologies and skilled staff. By contrasting these two figures (the $140 million merger gain and the $93 million loss without the merger), the analysis in your report highlights the promise of the merger in meeting the tremendous pressures on academic medical centers today, if UCSF Stanford is given sufficient time to secure the benefits of integration.

We should also point out one rather technical but important point in your analysis: included within the merger-related costs is $17 million per year of added pension costs due to the move of UCSF Medical Center staff out of the University of California's fully funded pension plan. While this is an added expense on UCSF Stanford's books, it is, as you point out, really a transfer, because the funding remains in the University of California pension plan to benefit the University's budget in future years. The loss of $19 million that you attribute to the merger during its first 22 months would have instead been a $12 million gain, were it not for this pension transfer.

When we were planning the creation of UCSF Stanford Health Care over two years ago, we knew that merging two academic medical centers would be very challenging, but it has turned out to be even more complicated than we anticipated, and it has taken longer to accomplish. In particular, integrating clinical programs has proven more complex—both here and at other academic medical center mergers across the nation. This process is difficult to drive from the top down. Clinical integration works best when led by faculty responding to issues and opportunities specific to their own programs, as evidenced by the successes you note in children's services, adult cardiac care, gynecologic oncology and clinical laboratories. This "bottom-up" approach, while more effective, does takes longer.

We also need to strike a careful balance between enterprise-wide integration and site-based accountability. Organizational changes have been made in the past several months to strike this balance more effectively, while keeping the framework needed to allow joint programs to begin, grow and flourish. The 10% increase in patient activity since the merger (against the trend of declining hospital utilization noted in your report) reflects clinical program growth and marketing efforts that both build on historic strengths at the two medical centers and leverage new opportunities created by the merger. As your report notes, additional income from merger-related patient activity exceeds the target in the merger business plan by $46 million over four years. We believe that this demonstrates a sophisticated and successful effort in program development and marketing.

Our physicians, staff, management and Board of Directors are especially proud of the outstanding quality of medical care that UCSF Stanford Health Care provides to patients from throughout northern California and beyond. We are equally proud of our commitment to increasing patient access and enhancing community service. As you note, UCSF Stanford spends more that 7% of its revenues ($110 million annually) on charity care and other community benefits, compared to an average of 1.3% at other California hospitals. We are pleased that your report recognizes the contributions made in these important areas over the past two years, building on the considerable efforts of the two predecessor medical centers.

In summary, your report shows the complexity of academic medicine, the challenges facing UCSF Stanford Health Care and other academic medical centers in California and nationally, and most importantly the promise of the merger if it is given the flexibility and the time to succeed. Again, thank you for your efforts and for the opportunity to respond.

Sincerely yours,

(Signed by: Isaac Stein) *(Signed by: Howard Leach)*

Isaac Stein
Chair,
Board of Directors

Howard Leach
Vice Chair,
Board of Directors

cc: Members of the Legislature
Office of the Lieutenant Governor
Attorney General
State Controller
Legislative Analyst
Assembly Office of Research
Senate Office of Research
Assembly Majority/Minority Consultants
Senate Majority/Minority Consultants
Capitol Press Corps