

The Regents of the University of California

HEALTH SERVICES COMMITTEE

March 3, 2017

The Health Services Committee met on the above date at the Luskin Conference Center, Centennial Hall, Salons C & D, Los Angeles campus.

Members present: Regents Blum, Lansing, Makarechian, Reiss, and Sherman; Ex officio member Lozano; Executive Vice President Stobo; Chancellors Hawgood and Khosla; Advisory members Hernandez, Lipstein, and Smith

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

The meeting convened at 1:00 p.m. with Committee Chair Lansing presiding.

1. PUBLIC COMMENT

Committee Chair Lansing explained that the public comment period permitted members of the public an opportunity to address University-related matters. The following person addressed the Committee concerning the items noted.

Ms. Claire Miller, a UCLA student, expressed concern about possible changes to UC immunization policy regarding exemptions. Other state universities allow vaccination exemptions on the grounds of religion and personal belief, and UC should also allow such exemptions. She warned that eliminating the religious exemption might encourage discrimination lawsuits.

2. APPROVAL OF MINUTES OF PREVIOUS MEETING

Upon motion duly made and seconded, the minutes of the meeting of December 5, 2016 were approved.

3. REMARKS OF THE EXECUTIVE VICE PRESIDENT – UC HEALTH

[Background material was provided to the Committee in advance of the meeting, and a copy is on file in the Office of the Secretary and Chief of Staff.]

Executive Vice President Stobo recalled that a great deal of federal governmental activity was taking place regarding the Patient Protection and Affordable Care Act (ACA). The University was closely tracking these developments, relying on individuals within UC and colleagues from other professional organizations, such as the Association of American Medical Colleges, in order to understand these developments and determine the position the University should take. The University was particularly concerned about two issues: the possible removal of individual mandates and Medicaid expansion. The

position of the Republicans was to remove individual mandates and replace subsidies with refundable tax credits. The Republican administration also wished to remove funds for Medicaid expansion, instead providing block grants or per capita grants to states. Dr. Stobo presented a chart showing Medicaid expansion by state. In California, more than three million individuals had been added to Medicaid rolls, far more than in any other state. This represented a significant part of the total national Medicaid population, and if funds for Medicaid expansion were removed, this population would be at risk of not having any health insurance.

Advisory member Hernandez presented her assessment of the ACA situation. The issue of the Medi-Cal program would be especially salient for California. It appeared that the individual mandate would be repealed. The Medicaid expansion population in California was important in terms of numbers served and federal funding. California received \$20 billion by virtue of the Medicaid expansion alone. The Medi-Cal program served one of every three Californians; this reflected the fact that the state has a very large low-income population. Single adults or low-income individuals made up the majority of the Medicaid expansion population. The federal government had provided Medicaid expansion funding but fiscal conservatives in Washington, D.C., in particular in the House of Representatives, were concerned about the federal share of Medicaid expansion. Nevertheless, there were also many Republican-dominated states that had expanded Medicaid. The governors of these states were actively involved in discussions with the House of Representatives about Medicaid expansion funding. There was also growing awareness that the Medicaid expansion through the ACA was an important benefit and entitlement for people throughout the U.S.

The implications for California of block grants or a per capita cap were entirely unclear, because the methodology for how these would be applied was unknown. The size of the federal distribution to California was a result of the large number of individuals served rather than the amount spent per member. In fact, 41 states spent more per capita on Medicaid than California did. In terms of growth in costs, California's Medicaid program had been growing by only about three percent annually over the last decade. But because of the large number of members served, California would have a great deal to lose in any calculation about federal versus State funding of Medicaid.

Dr. Hernandez anticipated that changes to Medicaid would most likely be phased in after the 2018 midterm elections, which would allow California about two years to develop a response. She also anticipated that the Medicaid expansion would continue, but it was not certain how the question of federal versus State funding would be resolved.

There were many regulations in the Medi-Cal program that could be simplified, and California was seeking more efficient ways to deliver health care through telemedicine, by ensuring that mental and physical health care are provided to patients on the same day, and other means. This kind of flexibility was desirable.

If there were significantly less funding for healthcare benefits, there would necessarily be a discussion of which individuals or which medical conditions could not be covered. One

of the most important achievements of the ACA, arguably, was to integrate mental and physical health. The American healthcare system had begun to take this approach, and she stressed that this needed to continue. It would be undesirable to separate mental and physical health benefits. Dr. Hernandez concluded by remarking that patient age is often considered a foremost factor in decisions about granting subsidies, but in California, income is a more important factor, a factor that accounts for significant disparities in health outcomes.

Advisory member Lipstein explained that the ACA is divided into ten sections or titles. Title I covers insurance exchanges, subsidies that help individuals purchase insurance, and individual, employer, and insurance company mandates. Medicaid expansion is addressed in Title II. Title IX addresses funding, with fees levied on drug companies, insurance companies, medical device manufacturers, and tanning salons. Title IX also includes a “Cadillac tax” on excessive benefits. He anticipated that there would be an effort to repeal Titles I, II, and IX, while leaving other titles in place. Title III includes productivity improvements required of hospitals, readmission rate penalties, and other measures aimed at improving quality and safety.

Mr. Lipstein briefly described the Patient Freedom Act of 2017, which would not affect Title II and would not repeal Title IX, leaving funding in the ACA for whatever program would replace Title I. Each state would have three options. A state could re-implement Title I, with up to 95 percent of the funding that would currently be spent under the ACA. For states that would not wish to re-implement Title I, there would be a Republican alternative with health savings accounts for low-income individuals tied to high-deductible health plans and without mandated benefits. The third option would be to do nothing, not accepting any federal monies. The Patient Freedom Act, which had four Republican sponsors, would most likely not be passed.

Mr. Lipstein anticipated that the Republicans would not agree on a replacement program for Obamacare and would delay plans for a replacement until after the midterm elections of 2018. Nevertheless, the Republicans would have to address the individual health insurance market, which required changes in order to continue functioning. One “repair” would be to increase subsidies for individuals to purchase insurance. A second would be risk adjustment funding for insurance companies. This had been proposed as part of the ACA but was blocked by Republicans. Providing these monies would stabilize the market. A third measure that would provide more funds for insurance companies at the exchanges concerned the amounts charged to older versus younger patients. Currently, under the ACA older individuals can only be charged three times more than younger individuals; this could be expanded to five times. A fourth measure would be to reduce mandated benefits, and this would likely occur. Finally, assistance to states that did not expand Medicaid would win the support of Republican legislators in the current political environment.

Mr. Lipstein concluded that a great deal of funding was at stake for California. States with Republican governors that expanded Medicaid would play an important role. These

circumstances had dramatic implications for the healthcare sector. Dr. Stobo stated his view that none of these implications were positive.

Regent Blum referred to the option under the proposed Patient Freedom Act to re-implement Title I up to 95 percent. He asked what dollar amount the 95 percent would represent. Mr. Lipstein responded that the ACA would cost approximately one trillion dollars over ten years; the dollar amount for California would be significant.

Regent Blum suggested that the University should articulate its vision of a desirable outcome and seek the support of California politicians for this vision, a clear and comprehensible policy document. Dr. Hernandez observed that discussions were ongoing in California about a number of possible scenarios.

Mr. Lipstein noted that efforts were being made to convince relevant legislators to pursue repeal and replacement at the same time. Repeal of the ACA followed by a delay would be problematic. Most important would be to preserve Title IX. He differentiated what he viewed as the Republican, money-based approach to health care from the Democratic, people-based approach. In the money-based approach, when funding runs out, providers are no longer paid to provide health care to the poor and uninsured. In the people-based approach, all have funding for their health care needs, but the health care system may spend more money than the government has.

Regent Reiss asked about the major sources of funding for the ACA. Mr. Lipstein responded that the major sources of funding in Title IX are fees on insurance companies, medical device manufacturers, and drug companies. There are also taxes on “Cadillac” insurance plans, tanning salons, and capital gains taxes on high-income individuals. The other major source of funding is in Title III; hospitals and home care companies were no longer receiving inflation updates to their annual Medicare market basket adjustments. These two sources of funding were used to pay for either Medicaid expansion or subsidies at the health care exchanges.

Regent Reiss asked how much funding California received from the federal government for these subsidies. Dr. Hernandez responded that federal subsidies to California amounted to slightly less than \$5 billion, while federal spending on the ACA and Medicaid expansion in California amounted to about \$20 billion.

In response to another question by Regent Reiss, Mr. Lipstein responded that federal funding, as originally planned, would cover 100 percent of the cost of the Medicaid expansion in 2014, 2015, and 2016, then phase down to 90 percent of the cost by 2020, and remain at that level. Dr. Hernandez noted that numbers currently being discussed for federal participation in Medicaid expansion were far below 90 percent. She recalled that the reduction to 90 percent funding was related to a core tenet of the ACA, which was that health care providers would bring down the cost of care. There was an assumption that reductions in cost structure would offset reductions in federal funding.

Regent Reiss asked if the Governor and State leaders were developing a lobbying strategy on behalf of California. She asked if federal monies come through the State, or if they are received directly by hospitals. Dr. Hernandez responded that federal monies come through the State, through a variety of rather complex mechanisms. Responding to Regent Reiss' first question, she stated that the Governor's position was that the ACA was the law and that California should continue enrolling people in its health insurance exchange and in its Medicaid program. Many entities were beginning to undertake scenario planning for possible future action by the federal government. The U.S. Congress was currently very fragmented, philosophically and ideologically.

Advisory member Smith commented that most states receive a certain match of federal monies for health care provision. California's match is theoretically 50 percent, but in fact, as in most states, this percentage is higher. Most states have adopted a variety of strategies for generating "phantom money" as part of State expenditures that then is matched by federal funds and goes back to providers. He anticipated that whatever the future developments regarding the ACA, there would likely be increasing restrictions on these kinds of manipulations of formulas that have resulted in actual federal matches that are often substantially higher than the theoretical match. Dr. Smith also drew attention to the fact that many parts of the ACA were designed to promote value-based care. There was some concern among healthcare professionals about a reversal of the trend toward value-based care. In recent years UC Health operations had reflected this trend more than the influence of the insurance market. The University should be mindful not only of major budgetary issues but also of the move toward value-based care. Dr. Smith anticipated that this move would continue, but its pacing might change.

In response to a question by Regent Makarechian about the Medicaid expansion population, Dr. Hernandez stated that California was spending slightly more than \$6,000 annually per Medicaid-eligible individual. The expansion population was slightly more than three million people.

Regent Makarechian reflected on the enormous impact of the Medicaid expansion on UC Health. He asked about meeting the need for additional capacity. Dr. Hernandez responded that additional capacity had been built with an assumption about revenues. She also recalled that many individuals who joined the Medi-Cal program had previously never had any health insurance. This population entered the program with many unmet needs and with chronic disease conditions. Average numbers do not provide an adequate picture of the people being served by California's health system.

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

[Background material was provided to the Committee in advance of the meeting, and a copy is on file in the Office of the Secretary and Chief of Staff.]

UCSF Chief Medical Officer and Executive Vice President – Physician Services Joshua Adler presented the clinical quality dashboard, which is intended to align with UC

Health's clinical strategic plan, and present benchmarks that are meaningful to patients and actionable. He briefly outlined the development of the dashboard to date as well as features that would be added in the future.

Dr. Adler then presented charts showing benchmark data from third quarter 2015 to third quarter 2016 for UC Davis, UCSF, UC Irvine, UC San Diego, Ronald Reagan UCLA Medical Center, and UCLA Medical Center, Santa Monica. The first benchmark was the Case Mix Index, a measure of severity or complexity of illness, and it showed that UC medical centers treat cases more severe or complex than the average. The next benchmark was inpatient mortality, which had shown improvement over the last two quarters surveyed. UC medical centers had focused particular attention on preventable surgical mortality and sepsis. One factor affecting this benchmark was the fact that UC medical centers do not move patients to hospice settings, and UC does not own or operate hospices.

In response to a question by Advisory member Hernandez, Dr. Adler confirmed that all UC medical centers have palliative care programs, but have not instituted inpatient hospice beds. This would change the licensing of beds and mean that non-hospice patients could not use them.

The next benchmark was excess bed days, a measure of efficiency. Dr. Adler explained that if this benchmark is at zero, it indicates that patients are using exactly the number of days of hospital care they need, based on national averages. A positive benchmark number indicates excess length of stay, while a negative number indicates operating at a higher efficiency than average. This benchmark is one of the goals included in the Clinical Enterprise Management Recognition Plan. UC's medical centers were reducing the number of excess bed days.

Regent Sherman asked why UCSF had a higher number of excess bed days than most other UC medical centers. Dr. Adler attributed this to UCSF's bone marrow transplant program and to some surgical services, where length of patient stay was longer than it should be. UCSF was seeking to make optimal use of nearby outpatient housing facilities. The campus had purchased a facility in collaboration with a non-profit organization, Family House, to allow patients to receive inpatient care in the hospital and then transition to Family House to complete their treatment. In surgical services, UCSF was making efforts to improve the overall process of care so that patients move through this process in a timely manner.

Dr. Hernandez referred to UC Health's fiscal year 2017 goal of reducing excess bed days by four percent and asked how this goal was determined. Dr. Adler responded that this goal was based on progress achieved in the past; he acknowledged that UC Health could set a higher goal.

Chair Lozano asked how the Regents should use these data to hold UC Health accountable for good outcomes, and how this information can be made actionable.

Committee Chair Lansing remarked on significant fluctuations shown in the charts from one quarter to the next. She asked how these benchmarks would be addressed and why the fluctuations seemed so erratic over time. Dr. Adler responded that UC has reasonable experience and understanding of how erratic the data are in health care generally. There are specific interventions for each one of the benchmarks, and the UC medical centers were pursuing these interventions.

Committee Chair Lansing and Regent Sherman stressed that they would like to know what actions UC Health would take to improve outcomes and to address increases in various factors shown in the charts. Regent Makarechian referred to the chart with data for inpatient mortality. He asked about reasons for the UCLA and UCSF data, which showed decreases followed by increases. Dr. Adler responded that all patient deaths at UC medical centers are reviewed to identify possible gaps in care. The inpatient mortality data are an observed to expected ratio, and the case of a single patient can create an uptick in the data. That one case might represent an opportunity where UC Health could have performed better, or it might be due to the fact that a patient was severely ill rather than somewhat ill. Dr. Adler observed that consistent movement up or down over several quarters is a more certain indicator of change than change from one quarter to the next. UC Health was focusing especially on reducing mortality due to sepsis.

Advisory member Lipstein emphasized that these trend data were not as precise as one might believe. Expectations about mortality are based on how medical information is recorded and coded. Record documentation and coding is done by different people. One must examine data over several quarters and consider general direction rather than expecting precision. There would be variability from time to time. Some benchmark data reflected factors outside the hospital. There is a demonstrated correlation between individual and community indicators of poverty and readmission rates. He asked which of the UC hospitals takes care of the highest percentage of low-income patients, noting that these data were not adjusted for socioeconomic factors.

Referring to Committee Chair Lansing's earlier remarks, Dr. Adler observed that the science of quality improvement suggests that better quality is associated with smaller degrees of variation. If UC medical centers' performance is improving, then fluctuations should become smaller and there should be more predictability. He then discussed the next benchmark, readmission rates. UC medical centers did not perform as well as desired on this factor, despite significant efforts in safety, standardized discharge approaches, follow-up with patients who have returned home, and formal UC relationships with nursing homes, rehabilitation facilities, and home care agencies.

In response to a question by Regent Makarechian, Dr. Adler stated that UC Health would establish a goal for this benchmark. UC Health readmission rates were higher than average for academic medical centers, using a methodology that does not include risk adjustment for socioeconomic status. This was a flawed measure, and the University was penalized for it. One benefit of the efforts to reduce readmission rates was that UC gains more understanding of how it can provide care at lower cost.

Regent Reiss asked if UC readmission rates were higher than at hospitals with similar patient populations. Dr. Adler responded in the negative. The comparator hospitals were also academic medical centers, with patients with similar severity of illness, but not necessarily with similar socioeconomic status. Patient socioeconomic status is a difficult factor to know with certainty, and as a single factor it does not explain the challenge of readmission rates. Other social determinants of health also play a role, such as whether a patient lives alone or with another person. Mr. Lipstein observed that interventions to reduce readmission rates have to be customized to the individual patient's life circumstances. He asked which UC hospital provides the largest share of services to the uninsured. Dr. Adler responded that he did not have but could provide this information.

Mr. Lipstein noted the lower readmission rates shown for UC Irvine. Dr. Adler stated that patient care at UC Irvine was not very different from that at the other medical centers; UC Health was not aware of any differences that would account for lower readmission rates at UC Irvine.

Dr. Adler briefly reviewed data for another benchmark, central line-associated bloodstream infections. Improvement in this area depended on, among other things, ensuring that best practices are used diligently, with every patient. UC Health rates were good, but there was room for improvement. Committee Chair Lansing stressed that UC Health should strive to reach a zero infection rate. This goal could be achievable, since infections occurring in the hospital are a factor within UC's control. Dr. Adler then briefly presented data on catheter-related urinary tract infections, noting that a zero infection rate was potentially an achievable goal.

Finally, Dr. Adler discussed patient satisfaction scores. All UC Health institutions were above the 50th percentile for this benchmark. UC medical centers were making efforts to improve communication with patients and families, communication about the plan at discharge, and cleanliness of facilities. Advisory member Smith suggested that this benchmark was broad, a summary score; a benchmark with data on pain control, or other factors that are problematic, might be more helpful and actionable than this information. Dr. Adler responded that UC Health could provide more information on individual domains that contribute to patient satisfaction.

Regent Reiss asked about the patient satisfaction survey. Dr. Adler responded that the survey contains more than 40 questions, mandated by the Centers for Medicare and Medicaid Services. The University cannot change the survey questions, but can add questions. The survey is robust and much information can be gleaned from it about patient experience. UC Health is attentive to survey results and differences among medical centers. Patients receive the survey within five days of discharge. The response rate in general is low, between six and 12 percent. An important factor is language. A patient whose primary language is not English is much less likely to respond.

Regent Sherman suggested that presenting data for eight to 12 quarters, rather than just four or five, might show overall trends more effectively, and might show that trends were smoother than the ups and downs in the charts shown in this presentation.

Chair Lozano asked how these benchmark data were used to review the performance of chief executive officers. It would be helpful for the Regents to see how these data are translated into the work and focus of chief executive officers on areas that need the most improvement. Chancellor Hawgood responded that UCSF data were reviewed every month by the campus executive medical board, about 50 leaders of the clinical enterprise. Data are also reported to the Chancellor and leaders of the administration executive team. Each month UCSF selects one unit for deeper data analysis; this deep analysis rotates among UCSF's units. Chancellor Hawgood expressed certainty that similar types of review were taking place at the other medical centers. He also drew attention to the fact that the information in the charts was subject to a "law of small numbers." The vertical axes on most of these charts did not show values from zero to 20, but smaller values, such as 0.6 to 1.1. What appeared as a large jump on the chart for hospital-acquired pressure ulcers might be caused by one or two patients.

5. **REPORT OF THE UC HEALTH EXECUTIVE COMPENSATION WORKING GROUP: PROPOSED CHANGES TO THE MARKET REFERENCE ZONES FOR SENIOR MANAGEMENT GROUP POSITIONS IN UC HEALTH**

[Background material was provided to the Committee in advance of the meeting, and a copy is on file in the Office of the Secretary and Chief of Staff.]

Vice President Duckett recalled that a working group had been formed to develop a benchmarking framework for use in evaluating compensation proposals that may be approved under authority delegated to the Committee, a benchmarking framework that identifies peer institutions against which UC Health competes for high-level positions and considers external salary data for positions comparable to those which may be approved by the Committee.

Executive Director Dennis Larsen explained that the working group was tasked with defining a competitive market peer group and examined a cohort of national medical centers as well as academic peer groups and academic medical centers. The working group chose academic medical centers as the appropriate peer group and then considered criteria to be used for purposes of comparison. It identified operating net revenue and full-time equivalent staff as appropriate criteria. Applying these criteria resulted in cohorts that were essentially similar to each of the medical institutions. UCSF and UCLA, with similar scope and complexity, ended up having essentially the same cohort of comparators, but the smaller institutions like UC Irvine had their own. The working group found that, contrary to the early approach for Market Reference Zones (MRZs), in which there was one MRZ for all chief executive officers, there was in fact a significant divergence in market data, and to combine positions as they had been under the earlier methodology would not be appropriate for each of the positions. The working group decided to move in a different direction and assign MRZs to each individual position for each institution. In this manner, the MRZ would be reflective of that institution's and that position's scope of responsibilities and the comparable data appropriate for that institution.

In response to a question by Advisory member Lipstein, Mr. Larsen explained that the new MRZs reflected base salary only. MRZs are intended to address the base salary of each individual in relation to the market. Data on total cash compensation were also available.

Executive Vice President Stobo stressed that this was a reexamination of and a guideline for the MRZs, not a mandate to increase or to change salaries as of an effective date. It was simply an updating of MRZs to ensure that they are truly market-based. Mr. Larsen added that the proposed MRZs were a reflection of the actual market for hiring and retaining staff for each of these positions and comprised of data from institutions of comparable size and complexity. Regent Reiss added that the University's MRZs are periodically updated by an independent firm. Mr. Larsen identified the firm as Sullivan Cotter in this case.

Mr. Lipstein pointed out that the methodology employed by Sullivan Cotter was consistent with the methodology used throughout the industry. This was a very rigorous analysis, and the working group discussed it at length. The working group learned that there is a difference between compensation levels at public universities versus private universities, versus private academic medical centers that are not university-based; yet the market for executives exists among all three of these types of institutions. The Regents would have to consider this factor when they evaluate compensation. Mr. Larsen noted that UC's public and not-for-profit academic medical centers were compared only to public institutions, and this comparison showed that compensation levels for UC Health chief executive officers were close to chief executive officer salaries at comparator institutions, within a range of approximately eight percent. Below the chief executive officer level there was a negligible difference.

In response to a question by Regent Makarechian, Mr. Larsen explained that the working group used net operating revenue and full-time equivalent staff as criteria. Regent Makarechian asked about the appropriateness of revenue as a criterion. Mr. Lipstein observed that performance measures such as profitability or other quality criteria are considered in determining the variable component of compensation. The fixed part of compensation is market-based, while variable compensation is performance-based.

Regent Blum asked if bottom-line revenue was used as a criterion. Mr. Lipstein responded that bottom-line revenue was typically not considered in the not-for-profit sector. The methodology used by Sullivan Cotter evaluated size based on the number of employees in the organization, as well as the revenue base. Typically, bottom-line performance is not used as a criterion in an industry where revenue is determined by acts of the Legislature. Medicare is determined by acts of Congress and Medicaid by acts of the State Legislature. The Regents have the opportunity to consider profitability as a factor in assessing where in the MRZ an executive should be positioned or in that individual's variable compensation.

In response to a remark by Regent Makarechian, Mr. Lipstein confirmed that cost management is a criterion in UC's evaluation process. Mr. Larsen added that this issue

can be addressed through the incentive plan. Executives receive incentives to create efficiencies or cut costs. Regent Reiss and Mr. Lipstein noted that UC considers cost-cutting and wise stewardship of resources in evaluations for hiring and in performance evaluations.

In response to a question by Dr. Smith, Mr. Larsen confirmed that the MRZs addressed base compensation, but not variable compensation. Dr. Smith asked if there would be any significant difference if the MRZs considered variable compensation. Mr. Larsen responded that the new MRZs indicated that UC Health was at about 90 percent of the market median for base salary, and at about the same level for total cash compensation.

6. **ENDORSEMENT OF REQUEST FOR BUDGET AND DESIGN APPROVAL FOR THE PRECISION CANCER MEDICINE BUILDING AT MISSION BAY, SAN FRANCISCO CAMPUS**

The President of the University recommended that the Health Services Committee endorse UCSF's proposed request to the Finance and Capital Strategies Committee at its March 2017 meeting for approval of the Precision Cancer Medicine Building, a new cancer outpatient building at Mission Bay, San Francisco campus.

[Background material was provided to the Committee in advance of the meeting, and a copy is on file in the Office of the Secretary and Chief of Staff.]

Chancellor Hawgood explained that this project, the Precision Cancer Medicine Building at UCSF, had been approved in concept in 2008 as the Cancer Outpatient Building and had received preliminary plan funding approval in September 2015 for \$16.6 million. This would be the final building of Phase I of the UCSF Medical Center at Mission Bay, and an important element in UCSF's clinical cancer strategy, which aims to consolidate and expand cancer outpatient services at Mission Bay. The project would also complete UCSF's strategy of developing a regional cancer network, part of a comprehensive approach to provide specialty cancer care at Mission Bay. The Precision Cancer Medicine Building's strategic rationale and value include enhancing patient care, strengthening UCSF's market position, and earning a positive financial return. The building would provide state-of-the-art diagnostic and treatment alternatives, and support clinical faculty and researchers, allowing for more tightly integrated clinical and research teams across a variety of tumor- and genomic-based programs. The demand for UCSF's cancer services has been growing rapidly and exceeds the currently available space at UCSF. The Precision Cancer Medicine Building would allow UCSF to meet the growth in market demand and support an increase in market share. It would advance UCSF's regional and national position in cancer care and release space on the Mission Bay and Mount Zion campuses for other clinical programs.

Cancer services are among the most profitable programs within UCSF Health. The new building project would have a positive effect on net income, days' cash on hand, and debt service coverage. The cost for the project was \$275 million, to be funded with a projected

\$100 million in gifts and \$175 million of campus equity. The campus currently had \$51.5 million in pledged gifts.

The Precision Cancer Medicine Building would be located adjacent to inpatient cancer services, with 180,000 gross square feet and 120 cancer specialty clinics, 45 infusion bays, three radiation oncology vaults, imaging laboratory services, pharmacy, and support services. The project would also include renovation of approximately 6,000 square feet in the adjacent outpatient building to create a connection and shared lobby for the two buildings. The design would facilitate care for the patient at one location rather than the patient moving for different aspects of care.

Chancellor Hawgood reiterated that the campus intended to fund the project internally, so the project would not increase UCSF's debt service. Incremental cash flow from the project was estimated to be \$15.7 million in fiscal year 2020, the first full year of operations, increasing to \$24.2 million in fiscal year 2022. The project was scheduled to be completed in spring 2019.

Regent Makarechian recalled that UCSF had the lowest debt service coverage ratio and the lowest number of days' cash on hand among all the UC medical centers. He requested assurance that this project would not affect UCSF's debt service. UCSF Health Chief Executive Officer Mark Laret explained that UCSF Health cash levels were low due to the opening of the new Mission Bay hospital two years earlier, and the associated debt and depreciation expense. UCSF Health had anticipated and planned for this decrease in cash resources; the Precision Cancer Medicine Building would provide more capacity in profitable cancer services and help UCSF restore cash levels to a higher level.

Regent Blum asked what percentage of cancer patients currently treated at the Mount Zion campus would come to the new facility, and if the cost of treatment per patient would be higher in the new building. Mr. Laret responded that some infusion and radiation oncology services would remain at the Mount Zion campus, but most other major cancer services would move to Mission Bay. There is an increased cost associated with moving from an older to a new facility. But UCSF also recognized a hidden cost in requesting that patients travel from one location in San Francisco to another, rather than having patients in a single location. UCSF expected that it could increase the volume of patients it treats. There was no shortage of other demands for the space at the Mount Zion hospital, which would continue to provide outpatient clinical services and might increase women's health services.

Advisory member Smith reflected on the economics of cancer care. The profitability of outpatient cancer care might be subject to changes by the Centers for Medicare and Medicaid Services. He asked how this might affect UCSF's projections. He also asked about UCSF's assumptions regarding future reimbursement for treatment of Medi-Cal patients. Mr. Laret acknowledged that much of the profit margin in cancer services is associated with infusion and radiation oncology, which are highly profitable services. In its financial planning, UCSF was anticipating modest increases in reimbursement and a

stable sponsor base in the future. UCSF has a strong regional referral base in Northern California.

In response to a question by Committee Chair Lansing, Dr. Smith clarified that a large share of money earned by private oncologists for treating cancer patients derives from the markup charged on infusion drugs, the difference between the amount paid for the drugs and the reimbursement the physician receives. Advisory member Lipstein stated that one of the top three costs in Medicare is off-label use of chemotherapeutic agents. Over 50 percent of chemotherapy is provided off-label. Drugs originally developed and marketed for one use were now being used to treat other kinds of cancers. Most chemotherapy is administered to patients in the last two years of life. Treatment is very expensive, and profitable for administering oncologists.

Chancellor Hawgood expressed the campus' belief that this building project was financially sound, in spite of changes that might occur in the healthcare field, and the conviction that this project was part of UCSF's mission. The outlook for cancer therapies was changing dramatically, and UCSF wished to be in the forefront of these developments.

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

7. APPROVAL OF SALARY ADJUSTMENT USING NON-STATE FUNDS FOR JOHNESE SPISSO AS PRESIDENT, UCLA HEALTH SYSTEM AND CHIEF EXECUTIVE OFFICER, UCLA HOSPITAL SYSTEM, LOS ANGELES CAMPUS AS DISCUSSED IN CLOSED SESSION

Recommendation

The President of the University recommended that the Health Services Committee approve the following items in connection with the salary adjustment using non-State funds for Johnese Spisso as President, UCLA Health System and Chief Executive Officer, UCLA Hospital System, Los Angeles campus:

- A. Per policy, continued appointment of Johnese Spisso as President, UCLA Health System and Chief Executive Officer, UCLA Hospital System, Los Angeles campus, at 100 percent time.
- B. Per policy, a market-based salary adjustment of 14 percent, increasing Ms. Spisso's base salary from \$876,000 to \$998,649.
- C. Per policy, continued eligibility to participate in the Clinical Enterprise Management Recognition Plan's (CEMRP) Short Term Incentive (STI) component, with a target award of 20 percent of base salary (\$199,730) and maximum potential award of 30 percent of base salary (\$299,595). Actual award

will be determined based on performance against pre-established objectives.

- D. Per policy, continued eligibility to participate in CEMRP's Long Term Incentive (LTI) component, with a target award of ten percent of base salary and a maximum potential award of 15 percent of base salary. As the LTI uses rolling three-year performance periods, the first possible award payout would be after the end of the 2018-19 Plan Year. Actual award will be determined based on performance against pre-established objectives.
- E. Per policy, continued annual automobile allowance of \$8,916.
- F. Per policy, continuation of a monthly contribution to the Senior Management Supplemental Benefit Program.
- G. Per policy, continuation of standard pension and health and welfare benefits and standard senior management benefits (including senior management life insurance and executive salary continuation for disability after five consecutive years of Senior Management Group service).
- H. Per policy, continued eligibility to participate in the UC Home Loan Program, subject to all applicable program requirements.
- I. Funding for this position will continue to come exclusively from UCLA Health revenues. No State or UC general funds will be used.
- J. This action will be effective March 1, 2017.

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

Background to Recommendation

The President of the University recommended approval of a market-based salary equity adjustment of 14 percent using non-State funds for Johnese Spisso as President, UCLA Health System and Chief Executive Officer (CEO), UCLA Hospital System, Los Angeles campus. Ms. Spisso has more than 30 years of leadership experience in healthcare, including service at University of Washington Medicine. Given the broad scope and level of Ms. Spisso's responsibilities, the UCLA Health System is recommending that her base compensation be moved to a more market-competitive and appropriate position in the Market Reference Zone. UCLA Health proposes increasing her base salary from \$876,000 to \$998,649 as she continues to create a strong and efficient organization to support UCLA Health System's growth and strategic direction. The proposed salary action is warranted for an incumbent with extensive senior management experience and

reflects the increasing scope and complexity of UCLA Health, which includes four hospitals, a network of more than 150 primary and specialty care offices, and a physician practice plan and affiliation with the David Geffen School of Medicine at UCLA. Funding for this position will come exclusively from non-State funds, specifically from UCLA Health revenue. Ms. Spisso holds a critical role, brings significant experience to her role, and has demonstrated strong performance in her role.

Over the last year, Ms. Spisso has been instrumental in overseeing significant growth and realignment of the UCLA health organization, including:

- Expansion of UCLA Health Community Clinics and UCLA Faculty Practice Group Clinics (with a new total of 160 clinics in 75 sites throughout the region). These are now integrated into the Health System.
- Expansion of Clinical Services at UCLA Health's four hospitals (Ronald Reagan UCLA, UCLA Santa Monica, UCLA Resnick Neuropsychiatric Hospital, UCLA Mattel Children's).
- Expansion of facilities, including a joint venture with Select Medical for a 138-bed California Rehabilitation Hospital.
- Expansion of strategic partnerships, including a joint venture with AccentCare for UCLA Home Health Services and a joint venture with United Surgical Partners International and Tarzana Hospital for an Ambulatory Surgery Center.
- Planning and design for a new 160-bed tower addition to the Ronald Reagan UCLA Medical Center.
- Adding a major partnership with Los Angeles Lakers to serve as their Team Physicians, and naming rights to a training facility, including marketing opportunities.
- Achieving cost savings through a reduction in the Health System Executive Team (eliminated three positions that will result in a projected annual net savings of \$1.2 million, with the duties absorbed by the President and CEO and other senior team members).

The Regents' approval is required because this is a Level One position in the Senior Management Group (SMG). The proposed market-based equity adjustment would place Ms. Spisso's base salary at 0.2 percent below the 50th percentile of the Market Reference Zone (MRZ) for this position. Under Regents Policy 7701, Senior Management Group Appointment and Compensation, salaries near the 50th percentile of the MRZ will be assigned to SMG members who have significant experience in the position, who are proficient in the required skills, who are adept at managing the typical responsibilities, and who have documented and sustained high levels of performance.

[Background material was provided to the Committee in advance of the meeting, and a copy is on file in the Office of the Secretary and Chief of Staff.]

Executive Vice President Stobo explained that this proposed action was a merit-based salary adjustment for Johnese Spisso as President of the UCLA Health System and Chief Executive Officer of the UCLA Hospital System. Ms. Spisso's salary was low in market

terms and her performance over the past 12 months had been exceptional. Ms. Spisso's appointment resulted in administrative reorganization with net savings of approximately \$1.2 million. Regent Reiss noted that the proposed salary was well within market averages for competitor public academic institutions.

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

8. **UPDATE ON THE SCHOOL OF MEDICINE, RIVERSIDE CAMPUS**

[Background material was provided to the Committee in advance of the meeting, and a copy is on file in the Office of the Secretary and Chief of Staff.]

UC Riverside School of Medicine Dean Deborah Deas began this discussion by articulating the mission of the School, to improve the health of the people of Inland Southern California by training a diverse physician workforce and developing research and healthcare delivery programs to benefit the medically underserved. The School focuses on primary care and on specialty care. There is a dearth of specialty care services in the region. The UCR School of Medicine does not own or operate a hospital and consequently does not have clinical funds to support its academic enterprise.

Dr. Deas described the accreditation process for medical schools. In February 2017, the Liaison Committee on Medical Education (LCME) completed its site visit to UC Riverside for full accreditation, the third and final step required of all new M.D.-granting schools. LCME reviewers identified five strengths of the School, which they presented during an exit interview. LCME recognized the faculty, staff, and student commitment to the School's mission, the presence of a competent and cohesive leadership team, diversity throughout the School of Medicine, the Longitudinal Ambulatory Care Experience component of the curriculum, and the fact that the School ranked 45th among 84 public medical schools in total dollar amount of institutional grants and scholarships without a service commitment.

The UCR School of Medicine was in a phase of growth. It currently had 209 medical students, and its inaugural class would be graduating in June. The School also had 21 biomedical sciences Ph.D. students and 160 resident physicians from programs sponsored by the School and in affiliation with regional medical centers. The School had 240 full-time faculty members, and about 700 community-based faculty. The School's strategic plan is aligned with the strategic plan for the Riverside campus. The plan includes expanding access to medical care in Inland Southern California, creating new service lines that fill clinical care gaps in the region, developing a major medical center affiliation, enlarging the School's teaching platform, and providing a flow of funds to support the School's academic functions.

Senior Associate Dean Michael Nduati described clinical care goals. The School sought to enhance clinical care delivery through relationships with community hospitals, physicians, and other providers; train and retain new physicians who, it is hoped, will

address the shortage of physicians in the region; and measure and improve the health of the communities served by UCR Health. The School would fill gaps in specialty care services in the region, up to and including tertiary care, while quaternary care would still be referred to other UC medical centers. The School would develop research partnerships, including clinical trials, and would create Centers of Excellence.

Dr. Nduati enumerated some planning considerations for the School. The greatest challenge was the lack of medical center facility fees. Historically, there had been little graduate medical education in the region, but this had in fact been a benefit. Many of the School's hospital partners were beginning to develop residency programs and had not yet reached their medical resident limits. Due to the significant shortage of physicians in the region, the School could not fully rely on the community to provide a medical education platform. An important goal for the UCR Health clinical enterprise was to help expand the number of providers in order to build that platform. The School had been working diligently to develop a nascent clinical trials infrastructure.

The UCR School of Medicine also has strengths and opportunities. Being young and new, it has the advantage of flexibility and nimbleness, with a lean staff and management infrastructure. The School has the ability to expand graduate medical education rapidly. Faculty recruitment efforts have benefited from the UC Health brand. The School has been able to develop cost-neutral primary care by building a slight margin into its contracts. Dr. Nduati briefly outlined the School's various current service lines, the locations of clinical activity, affiliations, partnerships, and partnerships that might be developed in the future.

In the coming months, the School would be opening Citrus Tower, a multi-specialty outpatient center, and launching its electronic health record system on the UC San Diego platform. In four years, the School planned to build an outpatient pavilion, a 200,000- to 300,000-square-foot building next to the main campus, and within five years it hoped to develop an affiliation with a major hospital.

Regent Makarechian asked if the territories of the UC medical centers in Southern California had been defined. Executive Vice President Stobo responded that the leadership of the UCR, UC San Diego and UC Irvine Health systems had been working together, meeting on a regular basis to ensure that their plans complement each other and taking maximum advantage of collaborative opportunities; they were not in competition.

Advisory member Smith asked if the UCR School of Medicine could compensate for gaps in clinical facilities through use of simulation laboratories, which were used at UC Davis. Dr. Deas responded that UCR medical students might benefit from workshops or seminars at UC Davis. Dr. Nduati referred to the School's Longitudinal Ambulatory Care Experience program. In this three-year program, students are paired with physicians in a clinical setting where they acquire hands-on experience.

9. UPDATE ON THE SCHOOL OF NURSING, IRVINE CAMPUS

[Background material was provided to the Committee in advance of the meeting, and a copy is on file in the Office of the Secretary and Chief of Staff.]

UC Irvine Vice Chancellor Howard Federoff recalled that the Regents had approved the Sue and Bill Gross School of Nursing at UCI. This was a program ready to be transformed into a School. It has the imprimatur of high-quality faculty and an organizational structure appropriate for a School. This was an opportunity for the nascent UC Irvine College of Health Sciences, which anticipated the development of several other schools in the future. The new School platform would allow innovation such as inter-professional educational programs and practice. He emphasized that UC Irvine had built a solid financial model for the School to sustain the ambition to grow slowly and meet its educational, pedagogical, and scholarship goals.

Committee Chair Lansing requested clarification of a financial summary chart for the medical centers presented by Executive Vice President Stobo during his earlier remarks. Dr. Stobo explained that in supporting programs and operations, there are above-the-line expenses and below-the-line expenses. Above-the-line expenses are ongoing recurrent costs, while below-the-line expenses include funding for new program development and recruitment of new faculty. In terms of income or loss, all UC medical centers were in the black but sometimes moved into the red after contributing funds to other parts of the institution, in particular to the medical schools.

Committee Chair Lansing asked if this was a reason for concern. UCSF Health Chief Executive Officer Mark Laret responded that above-the-line expenses were associated with running a hospital. Below-the-line expenses reflected decisions by the medical centers on how to use their cash: one could add days to days' cash on hand, build new facilities, or support partner enterprises. For UCSF, investing in programs in its School of Medicine was a high-return investment that would lead to clinical care developments and new revenue. UC San Diego Health Chief Executive Officer Patricia Maysent added that UC medical centers need to pay their faculty market rates. Part of the below-the-line investment moves faculty to market-rate salaries. Dr. Stobo confirmed that these financial factors at the medical centers are carefully monitored.

The meeting adjourned at 3:25 p.m.

Attest:

Secretary and Chief of Staff