The Regents of the University of California

HEALTH SERVICES COMMITTEE
June 14, 2023

The Health Services Committee met on the above date at the Luskin Conference Center, Los Angeles campus and by teleconference meeting conducted in accordance with California Government Code §§ 11133.

Members present: Regents Guber, Makarechian, Park, Pérez, Reilly, and Sherman; Executive Vice President Byington; Chancellors Block and Hawgood; Advisory members Marks and Ramamoorthy

In attendance: Regent Batchlor, Faculty Representatives Cochran and Steintrager, Assistant Secretary Bricker, Deputy General Counsel Nosowsky, Chancellor Khosla, and Recording Secretary Johns

The meeting convened at 1:05 p.m. with Committee Chair Pérez presiding.

1. **APPROVAL OF MINUTES OF PREVIOUS MEETING**

Upon motion duly made and seconded, the minutes of the meeting of April 12, 2023 were approved, Regents Guber, Makarechian, Pérez, Reilly, and Sherman voting "aye."[1]

2. **PUBLIC COMMENT**

There were no speakers wishing to address the Committee.

3. **SYSTEMWIDE STRATEGIC INVESTMENT PLAN AND UC HEALTH DIVISION FISCAL YEAR 2023–24 BUDGET, OFFICE OF THE PRESIDENT**

[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 Byington began the discussion by stressing the size and complexity of UC Health. When she first came to UC, one of Dr. Byington's goals had been to develop a comprehensive strategic plan for the entire UC Health system, but this had been interrupted by the COVID-19 pandemic. UC Health had worked with a consultant over the last year on this plan, considering many of the structural changes occurring in the healthcare arena that create both challenges and opportunities. The growth of government payers, commercial payer consolidation, and vertical integration were reshaping the healthcare markets. Other factors were the entry of private corporations like Walgreens and CVS and various health technology firms into the healthcare sector, an aging population, and workforce shortages which have been exacerbated following the pandemic. There had

[1] Roll call vote required by the Bagley-Keene Open Meeting Act [Government Code §11123(b)(1)(D)] for all meetings held by teleconference.

been an acceleration of digital health and advances in artificial intelligence. There had been changes in federal and State policies. There were many forces reshaping the University's role including pressures on revenues, expense growth, labor and capital requirements, increasing demands on the profit margin, and UC's promise of health equity. Hospitals around the state were under pressure; some hospitals might be closed or sold, and this would affect UC Health.

UC Health was both an academic and a clinical enterprise, and an enterprise with a business function, and it must maintain margins in order to support its activities in hospital and academic settings. Dr. Byington presented charts which indicated how expense inflation was outpacing net revenues from patients; an increase in government payers who do not fully compensate the system for the cost of delivering care; an increased demand for health system support, drawn from the margins of the hospitals, currently almost $1 billion a year and increasing; and increasing capital expenditures for the UC Health obligated group with requirements for a minimum of days' cash on hand. Given this context, it was important that stakeholders agree on the most important items and issues which would direct the investment of central funds for UC Health.

Over the course of a year UC Health had engaged in discussions in many different venues, had conducted surveys and meetings, and through this course of debate and deliberation four areas had emerged as the most important to invest in collectively. The first was to partner with the State to realize improvements in access to health care for people across California and to realize improvements in health. The second was to increase access to clinical services in geographic areas where UC has already invested—the Inland Empire and the Central Valley. The third was to advance UC clinical operations and research excellence through shared analytics and clinical research consortia. The fourth was to continue to work and facilitate UC Health's collaborative initiatives that increase fiscal resilience. It was becoming more and more expensive to deliver health care in California and UC Health must optimize in every realm.

Regarding the first priority, partnership with the State, this would mean engaging with the State of California on CalAIM and Medi-Cal access strategies; seeking to augment workforce development and retention strategies, especially for underserved geographic areas and disciplines with a shortage of providers; and working to pursue other State priorities as they arise, such as the COVID-19 pandemic and advocating at the federal level for better Medicare reimbursement.

The second priority was increasing access to clinical services in the Inland Empire and the Central Valley. UC Health had a special responsibility to UC Riverside and UC Merced and would work as a system to develop clinical resources in these areas. Lessons learned at UC Riverside would be important as UC began to plan and develop an academic health center at Merced.

With respect to the third priority, to advance clinical operations and research excellence through advanced analytics and clinical research consortia, Dr. Byington underscored that the Center for Data-driven Insights and Innovation had matured and developed through the

pandemic. UC Health could not have gone through the pandemic without this resource and now there was an opportunity to apply this resource to many new and exciting areas to improve health care in California and to direct these advanced analytic capabilities to research and clinical settings beyond COVID-19. UC would work to strengthen its Cancer Consortium strategy to be able to fully realize the potential of having five National Cancer Institute–designated comprehensive cancer centers. UC Health would continue its population health and clinical quality operations work so that its hospitals remain among the best in the nation.

The fourth and final priority was to facilitate collaborative initiatives that increase fiscal resilience. UC Health would seek to enhance its integrated commercial payer strategy. Although government payers were increasing and there were fewer and fewer commercial payers, commercial payers represented $14 billion annually for UC Health. UC Health should consider participation in Medicare Advantage and would launch the next wave of the Leveraging Scale for Value initiative, addressing even more challenging costs such as capital equipment, contract labor, and shared services. UC Health wished to enhance the integrity of its obligated group and to determine how best to support major capital projects across the system and how to prioritize projects, given the needs of all the campuses.

Dr. Byington noted that this framework would be important for the next Executive Vice President of UC Health, as she prepared to transition to a different position. UC Health was a division of the Office of the President (UCOP), and she recalled work that had been done in recent years to review and restate UCOP's mission, vision, values, and strategic objectives. The UCOP mission statement included this language: "Through leadership we catalyze and strengthen the University of California system…" Dr. Byington stressed that UC Health would sustain and strengthen UC's position as the preeminent university system in the world. The core values of UC Health were in alignment with UCOP core values, and the UC Health strategic investment priorities she had outlined were in alignment with UCOP strategic objectives.

Associate Vice President Zoanne Nelson then discussed the UC Health division fiscal year 2023–24 budget. She outlined budget drivers that determined budget decisions. One imperative was to align resources with strategic priorities. Priorities that emerged in the course of many discussions were strengthening government relations and advocacy work and facilitating the Cancer Consortium and other systemwide programs. At the same time, the division understood that the financial well-being of the medical centers was under increasing pressure and that UC Health must also consider ways to absorb mandatory cost increases like merit and benefit increases. The fiscal year 2023–24 budget for UCOP approved by the Regents at the May meeting included the UC Health division budget of $33.4 million, a decrease from the budget presented the prior year for the current year of $37.8 million. The reduction was primarily due to the fact that the self-funded health plan group would migrate as of July 1 to Systemwide Human Resources. This would bring the management of UC's overall benefits program into alignment, and this move had been discussed and worked on at length. Besides this reduction of about $5.2 million and about ten full-time equivalent employees, there were only minor changes to the UC Health division budget, and these reflected financial constraints.

There were minor increases to funding provided by the campus assessment and the collaborative, and there were some trade-offs to achieve this budget. Some open positions, previously approved in the current-year budget, had been frozen to accommodate budget increases for advocacy and to fund the Cancer Consortium. The UC Health division had increased its vacancy factor, reduced some non-compensation expenses, and decreased the funding proposed initially for the Cancer Consortium. Ms. Nelson concluded the presentation by noting that the division was carrying out priority activities but with a smaller increase to the overall budget and drew attention to the Collaborative Performance report, which articulated the return on investment for the funds that the medical centers contribute to the collaborative budget.

Regent Makarechian referred to changes in the payer mix and information in the background material according to which the percentage of government payers at UC had increased from 63 percent in 2016 to 71 percent currently. He asked what this change represented in dollar terms. Dr. Byington responded that every percentage point of decrease in commercial payers and increase in government payers equated to a loss of $50 million.

Regent Makarechian referred to a list in the background material with an estimate of planned facility investments. These capital projects were not expected to be funded with 2020 Series N bond proceeds. This bond funding would not cover potential acquisitions by UCLA and UCSF. He expressed concern that there would be no funding available for future hospitals at UC Merced and UC Riverside. Dr. Byington responded that UC Health was committed to development of academic health centers at Riverside and Merced; this would require work by the entire UC Health system.

Regent Makarechian asked if there was an active search for potential hospital acquisitions. Dr. Byington responded that UC had been actively working to understand the distressed hospital landscape in California and to assess the risks and opportunities for the UC system. UC Riverside School of Medicine Dean Deborah Deas commented that the UCR School was a community-based medical school without a hospital which depended on affiliates for its clinical platform for medical students and resident training. Over the years, this had been problematic, and the situation was not improving. At the same time, the School had received additional funding to increase its class size, but it would not be able to do this in the absence of an academic medical center. One goal of UCR Health is to provide more access to health care for the population of the Inland Empire. UCR had engaged a consultant who was currently exploring multiple options, and potential hospital acquisition was one of the options being explored.

Regent Park asked if the strategic investment plan report had been broadly shared. Dr. Byington responded that the report was now being shared for the first time with this Committee; the report had been shared with UC Health campus leadership, including the chief executive officers, deans, vice chancellors, and chancellors.

Regent Park suggested that many elements in the report could be individual agenda items for the Health Services Committee. She asked if funding and financing decisions might be deferred for a year during a transition to new leadership. Dr. Byington responded that

UCOP would like to offer the new Executive Vice President some leeway to examine priorities and to allow for a thorough discussion of the financing for UC Health.

Regent Park asked what work would be accomplished in the absence of a decision on financing models. Dr. Byington responded that, as one had seen over the past four years, UC Health lacked financing for many projects, but work continued in these areas, nevertheless.

Regent Park observed that UC Riverside and UC Merced reflected the University's commitment to serve the underserved in California. She looked forward to more detailed plans for these campuses.

4. **COMMUNITY BENEFIT AND COMMUNITY IMPACT ANNUAL REPORT**

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

UC Health Director of Finance Todd Hjorth recalled that UC Health completes a report on community benefit and community impact annually. This requires a great deal of work by all UC Health locations and is an attempt to quantify the benefit to the communities served. All not-for-profit or tax-exempt hospitals are required to submit an Internal Revenue Service (IRS) form outlining their community benefits and there are specific rules and regulations on completing the report. The University, as an entity of the State of California, is not required to submit this report but does so voluntarily to benchmark itself and to quantify in a standardized way the good that it does in the communities it serves.

Mr. Hjorth presented a chart showing the amount of community benefit provided by UC Health over the last four years. There was a noticeable increase in fiscal year 2020, which included the first three months of the pandemic when UC hospitals faced a particularly difficult burden, and much was demanded of them. He presented results for fiscal year 2022. Net community benefit expenses, which would have been reported on IRS Form 990 Schedule H, were about $1.7 billion and represented about nine percent of total operating expenses. The University also provides uncompensated care for Medicare patients, another $1.9 billion, which brought total community benefits to $3.6 billion. There are also UC faculty practice groups who provide charity care and uncompensated care for Medicare and Medi-Cal patients. All these together totaled $4.4 billion, an increase of about nine percent over the prior year total of $4 billion.

Mr. Hjorth then compared these figures to those for tax-exempt hospitals statewide. In California, 206 not-for-profit hospitals combined contributed about $8 billion in community benefits while the six UC Health locations by themselves contributed $1.7 billion. UC Health provided about 25 percent of Medicaid care, about half of health professions education, and almost one-third of the total research contribution. In a mean comparison, dividing the total benefit by number of hospitals, UC Health's contribution was six times larger than the average.

Committee Chair Pérez asked what these numbers would be if the comparison were made by number of patient beds rather than by number of hospitals. Mr. Hjorth responded that these numbers could be provided.

Mr. Hjorth then presented a chart showing that UC Health's consolidated community benefits as a percentage of operating expenses, 9.1 percent, placed UC Health in the top 70th percentile of not-for-profit California hospitals with bed size greater than 230 beds, well above the median, which would be at six or seven percent. This comparison filtered out smaller hospitals. Finally, he presented examples of community programs that UC Health locations were proud of and wished to share with the Regents—youth programs at Davis and Los Angeles, programs focused on food security at Irvine and the UCSF Benioff Children's Hospital in Oakland, and health equity programs at Riverside, San Diego, and San Francisco.

5. **UPDATE FROM THE EXECUTIVE VICE PRESIDENT OF 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 Byington began her presentation by recalling the first time she addressed the Committee and introduced herself in December 2019. She had spoken of her personal experience of witnessing health disparities and of her own study and work to combat pandemics. Awareness of health disparities and combating pandemics had shaped her career as a physician. On that day, December 10, 2019, no one knew that just three weeks later one would be plunged into what Dr. Byington described as a species-level event and that the seeds of the global pandemic were already incubating. She presented a chart representing the history of all known pandemics, from the Antonine plague (165–180 A.D.) to COVID-19. Other significant pandemics were the Black Death, the bubonic plague that killed 200 million people in the 1300s, and the 1918 influenza pandemic that killed about 50 million people. The HIV/AIDS pandemic, first described at UCLA in 1981, had now killed 25 million to 35 million people and was ongoing. Compared to these pandemics, COVID-19 was smaller but not insignificant, the sixth-largest pandemic experienced by human beings in the history of the world.

Today, in June 2023, hospital admissions for COVID-19 were near the lowest they had been since the beginning of the pandemic. This did not mean COVID-19 was over, but it indicated that the health profession had more tools at its disposal and had a much better understanding of this disease and how to treat it. One had left the emergency phase and could focus on the future. Dr. Byington's next role would be that of advisor to President Drake on health security and she hoped, at a future meeting, to discuss a new health security function for UC and for the state.

One must look to the future and to how COVID-19 would develop. The UC Health systemwide Long COVID Working Group was advising on investment of resources. The Working Group had produced 12 long COVID clinical education modules which had been accessed more than 11,000 times by users in every state in the U.S. and in many other

countries. The Working Group had helped UC to structure clinics like one at UCLA which focused on patients with dysautonomia, a post-COVID neurologic condition.

In connection with the strategic priority to partner with the State of California in strengthening the health security of California, Dr. Byington had received, as principal investigator for UC Health, a two-year planning grant with the California Department of Public Health (CDPH) to develop a stable infrastructure based on the knowledge and capacities developed at UC and at CDPH during the pandemic. This would comprise seven work streams: combating misinformation; developing flexible and rapid clinical diagnostics; environmental surveillance for COVID variants as well as new viruses, primarily through wastewater; infectious disease modeling; using electronic health records and the capacities built in the Center for Data-driven Insights and Innovation for real-world data analysis; helping to translate data into active and good policy for California; and focusing on the health professional workforce needed to combat future pandemics.

Dr. Byington thanked and acknowledged the work of individuals in her office and outlined their contributions. Among other things, this group helps produce reports brought to the Committee and to external stakeholders, like the strategic investment plan and the community benefit report just presented. Other reports included the integrated commercial payer strategy, the collaborative performance reports that show return on investment, and reports on diversity, equity, and inclusion.

UC Health also works through a number of centers and institutes, including two that were launched during Dr. Byington's tenure: the Center for Climate, Health and Equity housed at UCSF and the UC Health Milk Bank housed at UC San Diego. UC Health had also grown and strengthened its interactions through the Global Health Institute which encompassed all ten UC campuses and through UC Biomedical Research Acceleration, Integration, and Development (UC BRAID) which included five medical centers and their clinical and translational science institutes.

Health systems were responsible for about eight percent of global greenhouse gas emissions. UC Health was a founding signatory to the National Academy of Medicine Climate Collaborative and to the White House health system climate response group and was a leader in implementing recommendations from these groups.

In July, there would be a UC Health Systemwide Grand Rounds focused on achieving diversity without affirmative action; this would be very important following a decision by the U.S. Supreme Court expected later that month. UC Davis had the third most diverse medical school in the U.S., and it had achieved this with approaches that had to be developed under Proposition 209. Other grand rounds had focused on long COVID, the clinical environment following the U.S. Supreme Court decision in *Dobbs v. Jackson Women's Health Organization*, and achieving health equity in mental health.

UC Health had also convened systemwide groups to expand inclusion at its campuses: the Group on Inclusive Leadership, a leadership development program for women across UC in the health professions, and the Group on Inclusive Research Excellence, which

supported research faculty from underrepresented groups. While these groups focused on the academic side of UC Health, the operational side was being addressed by the UC Systemwide Anchor Institution Mission Group with representation from all the medical centers.

Dr. Byington emphasized the medical centers' commitment to being community partners, as evidenced by the community benefit report presented at this meeting and by advancing the health and equity of communities through purchasing, hiring, and presence in the community to address community needs.

UC Health was using data to advance health equity. UC had signed the Health Equity Pledge to leverage data in addressing healthcare disparities. Through the Center for Data-driven Insights and Innovation, UC Health data were coded for race, ethnicity, language, and sex in a systematic way that allows this information to be used to identify health disparities. A few months prior, UCSF Health had received a national award for advancing health equity by decreasing the differences in hypertension outcomes for black patients compared to white patients by using and leveraging these data. UC Health was focusing on real world evidence development by asking questions of its giant nine-million-person database. A UC Health conference on "Harnessing the Power of Real-World Evidence" in April drew over a hundred participants from throughout the UC system.

The hiring of Tam Ma as UC Health Associate Vice President for Health Policy and Regulatory Affairs was an important step for UC Health to increase its representation in Sacramento and to be able to better communicate its message to State legislators. The most important message was about the role of the UC Health system in the State's Medi-Cal program and to increase transparency by sharing real data and numbers. Dr. Byington presented a chart showing the large percentages of Medicare and Medicaid patients treated at UC in various departments—ambulatory, surgery, emergency, and others. She hoped that these data would be used by faculty and other stakeholders to understand and demonstrate the very important role UC Health plays in the state.

UC Health assisted in the development of a proposal for management of the Frederick National Laboratory for Cancer Research. The proposal was currently under review, the site visit had just been completed, and one might soon find out whether this site would become a new National Laboratory for the University of California.

UC Health had developed a unified approach to identify eligible UC healthcare workers to receive State COVID-19–related retention payments. This effort resulted in $90 million in retention payments for over 60,000 healthcare workers at UC.

UC Irvine Health would become a model for the nation with a carbon-neutral hospital to be powered completely by electricity and solar energy. UC San Diego and UC Davis were welcoming Native American medical students into their Programs in Medical Education (PRIME)—Transforming Indigenous Doctor Education (PRIME-TIDE) and Tribal Health PRIME. New students were also being welcomed this year to a collaborative program

between UC Riverside and UC Irvine, the Leadership Education to Advance Diversity – African, Black, and Caribbean (LEAD-ABC) PRIME program.

UC Health was working to expand the PRIME model to all its health professions. Representatives of UC Health, the Office of the President, and UCSF were advocating in Sacramento for the DDS-ASPIRE program which, if funded by the State, would be the first dental PRIME program. UC Irvine and other campuses were developing "pre-health pathways," interdisciplinary professional development programs to recruit a diverse group of students and bring them into the health professions. UC had received $13 million from the State for these programs.

Dr. Byington briefly drew attention to a number of UC Health affiliations and activities. UCSF Health had an affiliation with Chinese Hospital in San Francisco, UC Davis Health had affiliations with Federally Qualified Health Centers, and UCLA Health had recently received a $25 million grant from CDPH for a street medicine program for caring for the homeless in Los Angeles.

The work that takes place across UC Health inspires and empowers students and trainees. In the past month a trio of UC medical students took it upon themselves to create a community health conference for all UC medical students in Sacramento to focus on community health work. This kind of work would become increasingly important as one considered the risk that California faced in the next several years following the COVID-19 pandemic and the risk posed by hospital buildings in California with inadequate seismic safety. These distressed or potentially distressed hospitals represented 68 percent of hospital discharges within the state. Dr. Byington presented a map showing the location of these hospitals; many were within 50 miles of a UC location. UC Health would be affected by this and must take a strategic approach to strengthen the health security of all California.

Dr. Byington concluded her final presentation to the Committee with words by the poet Mary Oliver (1935–2019): "Tell me, what else should I have done?/ Doesn't everything die at last, and too soon?/ Tell me, what is it you plan to do/ with your one wild and precious life?"

The meeting adjourned at 2:10 p.m.

Attest:

Secretary and Chief of Staff