

The Regents of the University of California

HEALTH SERVICES COMMITTEE

April 13, 2017

The Health Services Committee met on the above date by teleconference at the following locations: Luskin Conference Center, Centennial Hall, Salons A & B, Los Angeles campus; Punta Mita, Ramal Carretera Federal 200 Km. 19, Bahía de Banderas, Nayarit, Mexico.

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

In attendance: Secretary and Chief of Staff Shaw, General Counsel Robinson, and Recording Secretary Johns

The meeting convened at 12:35 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 persons addressed the Committee concerning the items noted.

- A. Ms. Colleen Knorring, a UCLA student, expressed opposition to UC's immunization policy. She stated that Merck, a company that manufactures a measles, mumps, and rubella vaccine, was being sued for vaccine fraud. She urged UC to make its doctors aware of the risks of vaccines.
- B. Dr. Jocelyn Stamat, a licensed physician, expressed opposition to UC's immunization policy. She emphasized the right to informed consent for medical procedures and products, and elaborated on the meaning of this right, including that there not be coercion of or undue influence on a patient. Dr. Stamat stated her view that requiring vaccinations as a condition of receiving higher education was unduly coercive and a violation of the medical code of ethics.
- C. Ms. Claire Miller, a UCLA student, expressed concern about the University denying vaccination exemptions on the grounds of religion and personal belief. Students must maintain the right to refuse medical products, especially if those products contain ingredients known to cause cancer. She stated that some vaccines have tested positive for glyphosate, an herbicide that may be carcinogenic.
- D. Ms. Tess Goodrich, a UCLA student, expressed concern about the negative effects vaccines may have on some individuals. UC's immunization policy was

forcing students to choose between their bodily autonomy and their right to attend a public education institution.

- E. Ms. Beatrice Montalvo, a resident of Ventura County, expressed concern about UC's vaccination requirements and the importance of students' right to informed consent. She alerted the Committee to a current video documentary series titled "The Truth about Vaccines."

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

Upon motion duly made and seconded, the minutes of the meeting of March 3, 2017 were approved, Regents Lansing, Lozano, Makarechian, Napolitano, Reiss, and Sherman voting "aye."¹

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 reported briefly on a meeting held two weeks earlier by the deans of the UC schools of medicine and the chief executive officers of the UC medical centers. At that meeting Dr. Robert Wachter of UCSF reported on his work with Google on patient data in efforts to predict outcomes and develop better clinical interventions. Google would like to extend this project to patient data from all UC medical centers. UC Health had been working on the question of how UC can best bring these systemwide data together and work most effectively with Google for the benefit of patients. UC Health was preparing a response to a Request for Proposals that Google has produced; Google was considering other health systems to partner with besides UC Health. The use of clinical data raises certain issues, and UC Health had asked President Napolitano to appoint a systemwide committee to examine this matter within 60 to 90 days. The committee would provide guidelines for future endeavors of this nature using clinical data. Other topics discussed at this meeting were how curricula could be shared systemwide among the medical schools, and how services might be shared among medical centers.

Dr. Stobo noted that a nationwide event would take place on April 22, the "March for Science." The March would make a statement about the importance of science in general, beyond just the issue of federal funding. The University had decided not to sponsor this event. UC monies would not be used to support the March, although otherwise the University supports the March and its purpose. UCLA School of Medicine Dean Kelsey Martin explained that while the University would not officially sponsor the March, the medical school deans were in agreement about the importance of effectively communicating the importance of research. Many students and faculty would take part in the March. One important concern of the University is the proposal for cuts in federal

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

funding to the National Institutes of Health, and specifically, reductions in support for facilities and administration or indirect costs. It was important for UC to be able to explain why this funding is essential for scholarship and research. In response to a question by Committee Chair Lansing, Dr. Martin affirmed that the March for Science would also convey a message about climate change along with its general focus on the importance of science.

Dr. Stobo presented a financial summary chart for the UC medical centers. In terms of cash flow, the medical centers were doing well. Losses experienced at UC San Diego were occasioned by the opening of the Jacobs Medical Center. He anticipated that UCSD would recover from this quickly, as would UCSF from losses due to the opening of the hospital at Mission Bay, and both campuses have plans for recovery.

Advisory member Dimsdale asked about the non-cash element of other post-employment benefits. Dr. Stobo explained that other post-employment benefits include future contingent liabilities, required by accounting rules.

President Napolitano commented on the Google project mentioned by Dr. Stobo. A committee would review the process of sharing patient data with Google, considering important questions of how these data should be shared. This issue would be the topic of further discussions. Committee Chair Lansing added that questions of ownership and intellectual property in this area are complex. Dr. Stobo observed that involvement with the Google project had shown that UC Health still had more to learn to work better as a system.

Regent Reiss requested that UCSF present its financial plan to the Committee. She also requested clarification regarding the non-cash element of other post-employment benefits mentioned by Dr. Dimsdale. Dr. Stobo responded that pension expenses include cash and non-cash liabilities. Due to accounting rules that recently went into effect, the University must account for other post-employment benefits, mainly health benefits, not only for the current year, but also potential liabilities for future years. UCSF Health Chief Financial Officer Barrie Strickland explained that the University's liabilities include cash contributions for the pension and retiree health benefits, which are very high, at close to 18 percent of salaries. The additional actuarial expense for UC Health mentioned by Dr. Stobo was considerable. Dr. Stobo added that these liabilities are taken into account by rating agencies.

In response to Regent Reiss' request for information on UCSF's plan to turn around its financial situation, Chancellor Hawgood stated that the campus could present a detailed plan. He remarked that for at least the last six years, UCSF had been planning for negative income for fiscal years 2016, 2017, and 2018 due to the opening of the Mission Bay hospital, which had added \$100 million in annual depreciation and interest. The numbers presented on the financial summary chart were in fact well ahead of UCSF's projected income statement.

Regent Sherman asked how the UC Davis Medical Center had managed a recovery between 2016 and 2017. UC Davis Health Chief Executive Officer Ann Madden Rice responded that UC Davis Health restructured its expenditures, including expenditures for overtime. Successful practices such as this are shared among chief operating officers and chief financial officers throughout UC Health.

Dr. Stobo stated that UCSF and UC San Diego would present their financial plans at upcoming meetings.

4. **UPDATE ON THE AFFORDABLE CARE ACT**

[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.]

Chief Strategy Officer Elizabeth Engel presented an update on the state of efforts to repeal and replace the Patient Protection and Affordable Care Act (ACA). While a bill proposed by the leadership of the House of Representatives, the American Health Care Act, no longer appeared to have a path forward, the debate on the ACA was critical, and it was important that the University remain engaged as the House continued to negotiate with President Trump in the near term, and more incremental legislative reforms and regulatory activities were on the horizon.

Ms. Engel recalled that the ACA had brought about many positive results. Twenty million more adults had gained health insurance coverage, and the nation's uninsured rate was currently below nine percent, the lowest ever. In many respects, the ACA had helped drive down escalating costs in the healthcare system, but the cost of obtaining coverage remained a serious concern. In 2017, premiums increased by an average of 22 percent in the healthcare exchanges. In spite of federal subsidies, more insured Americans were experiencing difficulties in affording coverage. There were also concerns about the stability of the insurance marketplace. Some health plans had exited ACA exchanges, resulting in fewer players and less competition in certain regions. Insurance premiums had not increased in California as much as elsewhere, and the state's exchange, Covered California, still provided many options. The ACA and the Medicaid expansion had reduced the rate of uninsured individuals by 59 percent in California. From the perspective of UC Health, comprehensive health insurance coverage and access to regular preventive and coordinated care lead to better outcomes and health for patients, and ultimately, to reduced costs for UC Health. Increased coverage also leads to decreased costs for uncompensated care at UC medical centers.

Ms. Engel observed that President Trump and U.S. Department of Health and Human Services Secretary Thomas Price have significant regulatory authority to affect the functioning of the ACA, especially as legislative efforts had stalled. Beginning in June, health plans need to determine whether or not they would participate in the federal exchanges, and on which terms. A number of kinds of action or inaction by the Presidential administration could affect the ACA marketplaces. The ACA mandates that individuals purchase health insurance. Without this requirement, or some alternative,

fewer young and healthy individuals would participate in the market and premiums would increase. Absent legislation, the Trump administration could soften the mandate through lax enforcement by the Internal Revenue Service or by creating broader hardship exemptions to the mandate. The perception of an enforced or an unenforced mandate could affect insurer pricing and market participation. Another significant issue in the near-term future was the ACA's cost-sharing subsidies, paid by the government to insurers to help offset out-of-pocket costs for low-income enrollees. The subsidies were currently the subject of ongoing litigation filed by Congress. Congress did not specifically appropriate funds for these payments and asserts that the administration is not authorized to issue these funds. The Obama administration had appealed a District Court ruling in favor of Congress and this appeal had been on hold in recent months. President Trump could choose not to defend this lawsuit and terminate the subsidies, which would result in significantly higher premiums and more health plans leaving the market. The University, along with many other groups and stakeholders, had sent a letter to the President asking him to continue funding these subsidies, which are critical to maintaining a stabilized insurance market in the near term. UC Health would carefully monitor policies and signals from the Trump administration.

In Congress, the House of Representatives leadership had been trying to advance legislation to repeal and replace the ACA. According to the non-partisan Congressional Budget Office, under this bill, 14 million Americans would lose health coverage the following year and as many as 24 million by 2026. The Congressional Budget Office also projected that in 2018 and 2019 premiums would be 15 to 20 percent higher. Current discussions reportedly concerned the possibility that states would be allowed to opt out of the ACA's benefits requirements and rating rules. While plans would still be required to cover everyone, they could charge more to individuals with serious illnesses, likely undermining coverage affordability for those who most need it. While it was not clear that even a modified version of this bill could pass, Congressional leaders would likely seek to advance some of these policies. UC Health would continue to monitor and engage in the ongoing debate.

As part of the ACA debate, House leadership had also been seeking to restructure the Medicaid program. Authorization for the Children's Health Insurance Program was set to expire in September; legislation to reauthorize this program might be seen as a vehicle for Medicaid reform if it did not move forward with the current bill. Policies being proposed would change Medicaid from an entitlement program into a per capita capped amount or block grant provided to the states. Currently, the federal government matches State Medicaid spending on an open-ended basis, covering a fixed percentage of the states' allowable Medicaid costs. With this structure, the program automatically responds to increasing demand. Under a block grant, states would receive a fixed amount of federal funding for their Medicaid programs; they would not receive additional funding if more people qualify for coverage in an economic downturn. Under a per capita capped allotment, states would receive a fixed amount of federal funding on a per beneficiary basis. Ms. Engel drew attention to the fact that under both these proposed methods, states would be responsible for 100 percent of all costs above the cap on federal funds. States would have to absorb the increasing costs of caring for an aging population and those

with chronic conditions, public health emergencies, and expensive life-saving drugs and technologies.

Proposals to cap the amount of federal Medicaid funding for states would likely result in cuts to state Medicaid programs. To compensate for federal cuts, states would either have to contribute their own funding or, more likely, limit eligibility, benefits, and payments to providers. Academic medical centers like UC Health serve a disproportionate share of Medicaid patients and proposals to restructure Medicaid would have a significant impact on these institutions. The bill currently before Congress would cut an estimated \$880 billion in federal Medicaid funding over the next ten years. Under the ACA, California receives \$4.6 billion in premium subsidies to more than 1.2 million Covered California enrollees, \$800 million in cost-sharing subsidies to these enrollees, and \$21 billion in federal funding for 3.7 million newly eligible adults.

UC Health's position and advocacy efforts are guided by certain overarching principles. UC Health believes that any effort at healthcare reform should seek to maintain at least the same level of coverage, care, and consumer protections that is currently available. UC Health is focused on protecting academic medical centers' capacity to treat the sickest patients and serve as vital safety nets for vulnerable populations, including ensuring adequate reimbursement for academic medical centers as a component of any plan that is advanced. UC Health was communicating with policymakers in Washington, D.C., to educate them about the potential impact that changes to the ACA would have on UC Health and its patients. UC Health was working closely with other preeminent academic medical centers in the U.S. as well as other groups and associations to communicate these concerns.

Of all issues related to the ACA, changes to Medicaid would have the greatest impact on UC Health. UC Health was continuing to work with the State to improve Medicaid reimbursement under the current law, actively negotiating to contract with health plans, and continuing its efforts to provide more coordinated and efficient care to the Medicaid population that it serves. Currently, UC Health's advocacy in Washington, D.C. was focusing on opposing significant cuts to Medicaid rather than negotiating terms of a restructured program.

Committee Chair Lansing asked about the extent of a reduction in funding the UC system could expect if the Medicaid program were restructured. Executive Vice President Stobo responded that the amount UC receives in aggregate for Medi-Cal payments was approximately \$3 billion. He anticipated that UC might lose at least 20 percent of that amount. He expressed his misgivings about the current situation. Usually, in the case of a fiscal threat, scenario planning is possible. There were many factors affecting the current situation and this made scenario planning difficult. The only certainty was that federal funding would be reduced. One of UC Health's major insurers was contemplating exiting Covered California in at least two of UC's markets; for each UC institution, this would represent a loss of \$15 million to \$20 million. Reauthorization of the Children's Health Insurance Program might change eligibility limits. The eligibility limit was currently at about 130 percent of the federal poverty level, but might be reduced to 100 percent of the

federal poverty level; this would have a tremendous financial impact on UC's children's hospitals. Ms. Engel added that governors of both political parties were concerned about large cuts to Medicaid that would shift costs to the states.

Committee Chair Lansing stated that the University needed to mobilize patient advocates at risk of losing coverage, whose stories would receive attention in the news media.

Regent Reiss reflected on the options available to California to manage reductions in federal funding for Medicaid, such as limiting eligibility or reimbursements to providers. She asked if there is a minimum level of reimbursement that states must meet and if California could lower the current reimbursement rate. Dr. Stobo responded that California's reimbursement rate was already low, the fourth lowest in the nation.

Advisory member Hernandez observed that it was unlikely in the current financial and political environment that the matter of provider rates would be addressed before beneficiaries and the scope of services were protected. The possible changes to Medicaid mentioned earlier, block grants and per capita caps, were being proposed under the guise of state flexibility. The State of California would receive flexibility and much less funding. California might choose to exert flexibility by directing available funds to providers in areas where populations have less access to health care. She stated that it was hard to imagine reimbursement rates for providers being even further reduced and advised that increased tax revenue would not be able to backfill the magnitude of reductions to Medicaid being proposed. Dr. Stobo emphasized that UC Health was acting on this matter and has a systemwide Medicaid strategy. One major element of this strategy is to have a massive services agreement with major Medi-Cal managed care plans in Southern California, plans which might receive more funds from the State under the scenario suggested by Dr. Hernandez. Another important element of UC Health's Medicaid strategy was to manage the healthcare of this population more effectively so that reimbursement is more closely aligned with costs. He stated his view that UC Health could do a better job in this care management. Ms. Engel added that reimbursement under Medicaid is very complicated, with multiple funds flows. It remained uncertain how and to what extent Medicaid payments would be affected by proposals currently being considered.

Advisory member Smith stressed that it was impossible at this moment to calculate the implications of all the changes being proposed for health care. It would take some time before a solid estimate would be possible.

Ms. Engel recalled that President Trump had called for significant reductions in National Institutes of Health (NIH) funding, 18 percent or \$5.8 billion for the next year's budget. Given widespread bipartisan support for NIH funding in Congress, such a reduction was not likely to take place, but the University should not be complacent. UC Health was actively working with partner organizations to advocate against cuts and in favor of a \$2 billion increase for NIH in 2018.

President Napolitano drew attention to the fact that reductions in NIH funding would include reductions in indirect cost recovery. Politically, it might seem attractive to assert that NIH can still invest in science but that funding for administrative overhead costs needs to be reduced. The Office of the President was engaged in scenario planning for indirect cost recovery, taking into account the different situations of UC campuses. Dr. Stobo cautioned that cuts to indirect cost recovery would have devastating effects on UC Health.

Dr. Smith stated that curtailing administrative costs was a valid strategy. Doctors and hospitals were being asked to cut costs in the current environment. While stressing the importance of facilities and administration or indirect cost recovery, the University should seek to reduce these costs.

UC San Diego Vice Chancellor David Brenner remarked that the NIH real budget had decreased dramatically over the past ten years. Medical schools receive less funding every year, corrected for inflation, and he stressed that UC's medical schools have become more efficient in managing facilities and administration costs. State institutions have lower indirect cost recovery rates than private institutions like Stanford or Harvard but are asked to perform at the same high level.

UCLA Health Sciences Vice Chancellor John Mazziotta reflected on the magnitude of some of the changes being proposed for health care. UC Health might have to contemplate structural changes much more extensive than simply increasing efficiencies.

5. **UC HEALTH AFFILIATIONS: FOLLOW-UP DISCUSSION ON QUALITY AND BRAND EXTENSION**

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

Executive Vice President Stobo observed that as UC Health becomes involved in affiliations, acquisitions, and partnerships with other facilities and providers, the Committee would have questions about how UC Health can ensure that the quality of UC affiliates is at an appropriate level and how it can ensure that there would be no dilution of the UC brand.

UCSF Senior Vice President Shelby Decosta began the discussion by noting that all UC Health enterprises must expand their networks to support their teaching, research, and clinical missions and in order to be financially sustainable. UC Health has a wide range of types of clinical affiliations, with varying degrees of integration and control.

The pursuit of clinical affiliations improves UC Health's ability to grow its business and extend its reach with independent partners who are financially stable and do not wish to be acquired or employed. Affiliations can be a cost-effective alternative to acquisitions, do not require significant up-front capital investment, and strengthen UC Health's competitive position, providing access to business in tertiary and quaternary care.

Affiliations allow UC Health to focus on its core mission and support its population health strategies.

Ms. Decosta outlined some of the risks of clinical affiliations: brand risks when expectations are not met, reputational risks when affiliates do not offer levels of quality comparable to those of UC Health enterprises, financial risks, and legal or regulatory risks. The health sciences campuses are working together to determine how UC Health should set minimum quality requirements regarding potential partners or affiliates and to determine brand guidelines and a framework for UC Health as a system.

Ms. Decosta described the work of the UC Health Quality Workgroup and its guiding principles. The Workgroup was currently developing minimum requirements and standards for evaluating potential affiliates. There would probably ultimately be six to ten criteria in a few key areas. One key area is “organizational attributes.” Another key area, “clinical and quality performance,” would include external rankings. UC Health is interested in developing affiliations with physician groups, but available data on these groups are very limited. In considering affiliations with physician groups, UC Health might apply criteria such as the presence of an electronic health record platform.

A second workgroup, the UC Health Brand Workgroup, was determining minimum standards and requirements for extending the UC brand to affiliates. At this point all the health sciences campuses were in agreement on a number of points: affiliates must meet minimum quality thresholds before the UC brand is extended to them; each campus would agree to assess the brand and reputation of an affiliate prior to agreement; and UC Health would set clear expectations about how the brand is to be used, with specific guidelines for how and where the brand can be displayed.

Chair Lozano asked how UC Health would apply standards of quality in entering affiliation agreements. Ms. Decosta responded that the UC Health Quality Workgroup was grappling with this question. The Workgroup would likely develop a short list of criteria as minimum standards. Dr. Stobo added that there would be a minimum standard for entry into an affiliation. He stressed that this would represent a minimum rather than optimal performance. UC Health would set further goals for affiliates and clear timelines for achieving those goals. If goals were not achieved, the affiliate could no longer use the UC brand. As part of the relationship, UC Health would be responsible for helping affiliates improve their quality, while in some cases UC Health could learn from affiliates.

Chair Lozano recalled that there is a continuum of types and levels of affiliations. In affiliations which approach full integration, UC Health assumes risks, liabilities, and consequences. She hoped that there would be different thresholds depending on the depth of the affiliation. Dr. Stobo responded that the discussion about the depth or degree of an affiliation should occur at the same time as the discussion about the quality of a potential affiliate.

UC San Diego Health Chief Executive Officer Patricia Maysent remarked that brand and quality go together. If UCSD Health has a minimal relationship with an entity, that entity is not allowed to use the UC brand. She observed that UC medical centers do not always have the best rankings and that UC affiliates sometimes outrank UC medical centers on various criteria.

Committee Chair Lansing noted that this last mentioned circumstance should provoke UC Health to examine itself. Ms. Maysent responded that the data used for rankings are not risk-adjusted and can be questioned. Nevertheless, these rankings are used by healthcare companies in evaluating the performance of hospitals. For UC Health, the ranking of an affiliate might be less important than an affiliate's willingness and commitment to work to improve quality and value.

Advisory member Smith remarked that governance and credentialing within physician groups is a challenge that needs to be given ample consideration. There may be as much variation within a physician group as across institutions, and UC Health's capacity to make distinctions about members in a group was an important issue. He noted that this has sometimes caused problems in institutional affiliations. Ms. Maysent concurred that this is a complex area and that there may be differences within a physician group in terms of quality and certification. UC Health would need guidance on this matter.

6. **ENDORSEMENT OF REQUEST FOR APPROVAL OF THE JOAN AND SANFORD I. WEILL NEUROSCIENCES BUILDING, PREVIOUSLY KNOWN AS MISSION BAY NEUROSCIENCES RESEARCH BUILDING (BLOCK 23A), 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 May 2017 meeting for approval of the Mission Bay Neurosciences Research Building (Block 23A) project, to be named the Joan and Sanford I. Weill Neurosciences Building, 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 presented this item, endorsement for the proposed Joan and Sanford I. Weill Neurosciences Building at UCSF, a research and clinical care building that would be critically important for enhancing UCSF's services in neuroscience. He noted that the design of the building had evolved since background information was sent to the Committee. The overall assignable square footage had increased to 208,000, with a slight increase in gross square footage to 274,000, and an overall building efficiency of 75 percent. UCSF was able to increase the overall assignable square footage by 18,000 through open office floor plans and adjusting the siting of the mechanical equipment from inside the building to the roof or exterior.

The building would provide a home for the new UCSF Weill Institute for Neurosciences. Approximately 70 percent of the building would be dedicated to neuroscience research and teaching and 30 percent to clinical care. The total cost would be \$357.6 million, to be funded with \$175 million in gifts, \$141.6 million in external financing, and \$41 million in campus equity. The external financing would be an obligation of the UCSF general campus. Of the \$175 million in gifts, \$125 million had been pledged through a bequest, \$25 million in gifts had been received, and \$25 million remained to be raised.

This project would form part of an impressive complex of neuroscience facilities at Mission Bay. The siting of the building would complete the Koret Quadrangle at Mission Bay, making it an important signature building for the campus. Research and clinical care would be located together in order to expedite translational medicine. The strategic rationale and value of the building included enhancing patient care and strengthening UCSF's market position in the neurosciences while generating a positive financial return. The facility would foster advances in neurology, neurosurgery, and psychiatry by providing the opportunity for more tightly integrated clinical and research teams and more effective collaborations, innovations, and discoveries.

The project would help expand UCSF's services in neuroscience, second in importance only to cancer services for UCSF Health. The demand for these services, particularly infusion therapy, was growing rapidly, and exceeded the space available at the Parnassus, Mount Zion, and Mission Bay campuses. The building would host expanded clinical services for neuroinflammatory disorders, movement and neuromodulation disorders, and neurodegenerative disorders. Patient care would be delivered in a variety of settings. From a financial point of view, UCSF's neuroscience programs are among its most profitable and generate positive cash flow. The building was projected to produce positive net income and earnings before interest, depreciation, and amortization in its second year of operations, with incremental positive cash flow of \$2.5 million in 2021 and \$2.8 million in 2024. Patient volume was anticipated to amount to approximately 14,000 clinical visits annually and 10,000 infusion visits annually. Chancellor Hawgood presented an architectural rendering of the six-story building. Pending Regents' approval, construction would begin in June 2017 with a target completion date of February 2020.

Regent Sherman asked about the difference between the gross square footage and assignable square footage and how costs would be allocated to research and other entities. Chancellor Hawgood responded that the project efficiency of 75 percent was high for a building of this nature, with these functions. The costs would be allocated based on functional use. UCSF would allocate operating costs to the UCSF Health system for clinical functions and to the campus for research- and teaching-oriented functions.

Regent Sherman asked if 100 percent of the cost would be allocated. Senior Vice Chancellor Paul Jenny responded that UCSF would allocate 100 percent of the cost; the pro rata share would be based on the assignable square footage, but the total operating cost, including debt service, would be based on gross square footage.

Regent Reiss praised the project but expressed concern about possible reductions in federal funding for research. She asked how UCSF and UC Health would take these enormous uncertainties into account for this and future projects. Chancellor Hawgood responded that a project of this nature has a very long lead time. Discussions about this building within UCSF and with the donors began more than two years earlier. UCSF was acutely aware of the uncertainty surrounding federal support, but Chancellor Hawgood noted that UCSF had seen a steady increase in its market share of federal research funding, about five to seven percent annually, even in times when the National Institutes of Health budget had stagnated. UCSF was making an assumption that a critical focus should be on talent and that the best talent would continue to be funded even in the worst of times. UCSF was examining the issue of indirect cost recovery, an important source of revenue for all its buildings and for its research enterprise. This building enjoyed strong donor support and UCSF did not anticipate any difficulties in securing the \$25 million still needed. He underscored that UCSF was carefully considering the issues raised by Regent Reiss, including the question of looking beyond short-term stresses toward a ten- or 15-year time horizon. He acknowledged that UCSF might change the scheduling for future building projects, but the campus anticipated moving ahead with this project as planned.

Regent Reiss stated that UC Health should carefully consider future projects and projects currently under way with the awareness that substantial changes were possible and that business might not be as usual for some time.

Advisory member Smith anticipated that UC Health would experience increasing stress, regardless of the outcome of federal budgets, with regard to contributions to public service, administrative and facilities costs, and reimbursement rates. Before this building opened, it would be advisable for UCSF to consider how the building would serve the people of California, in particular low-income people. The Weill Neurosciences Building and the building to be discussed in the following item involved highly specialized care in areas where UC Health is nationally preeminent. He suggested that UCSF should articulate what kind of services might be offered regionally, outside of the usual Medi-Cal contracting, and for Medi-Cal patients who have difficulty accessing neuroscience and psychiatry services. This strategy should be pursued for every new clinical building at UC. Chancellor Hawgood responded that the Global Brain Health Institute, a program focused on memory and aging, with international impact and in particular for regions with few health resources, would be housed in this building, supported by a gift from the Atlantic Philanthropies. He agreed that the case for the building could be stated more powerfully.

Committee Chair Lansing emphasized her view that this building had a strong narrative. Many medically underserved people have a need for care in this area and would benefit from research in neuroscience, which accounted for the Atlantic Philanthropies' interest in the work being done at UCSF. A strong narrative could be conveyed about this project.

Upon motion duly made and seconded, the Committee approved the President's recommendation, Regents Lansing, Lozano, Makarechian, Napolitano, Reiss, and Sherman voting "aye."

7. **ENDORSEMENT OF REQUEST FOR APPROVAL OF THE CHILD, TEEN AND FAMILY CENTER AND DEPARTMENT OF PSYCHIATRY BUILDING, 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 May 2017 meeting for approval of the Child, Teen and Family Center and Department of Psychiatry Building, 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 presented this project, the Child, Teen and Family Center and Department of Psychiatry Building, to be located at 2130 Third Street, in the Dogpatch neighborhood south of the Mission Bay campus. At the May Regents meeting, the campus would request approval in closed session for acceptance of the property gift, real estate transaction terms, and project financing using a third-party nonprofit organization to issue tax-exempt bonds. In open session the campus would request approval regarding the California Environmental Quality Act, design, and amendment of the campus' Long Range Development Plan. The project was made possible by a generous gift to UCSF of the land as well as cash contributions totaling \$30 million for operations, to be paid out over the next 12 years. The existing building on the site would be demolished. The Child, Teen and Family Center would provide outpatient psychiatric services for children, young adults, and adults, as well as many innovative, interdisciplinary clinical and clinical research programs.

The new building would be five stories high, with 170,000 gross square feet, with one level of below-grade parking. The programs in the building would bring together clinicians and researchers to address the most important problems in psychiatry, psychology, and the behavioral and mental health fields, with a focus on prevention, community outreach, integration of pediatric and adult medicine with psychiatric care, and development of novel and improved therapies. In 2016, UCSF chose SKS/Prado 2130 Third LLC to develop the site following a selection process. Upon approval of the project by the Regents, the property would be transferred to the University, which would enter into a master ground lease of the site to a nonprofit organization that would then sublease to the developer. The developer would be responsible for designing, building, maintaining, and operating the facility. UCSF would lease the space under an occupancy agreement. At the end of the lease term, UCSF would own the building outright at no additional cost.

This project would enhance patient care and strengthen UCSF's market position. The Child, Teen and Family Center would house programs currently located at San Francisco

General Hospital, including mental health programs for children. Clinical and research teams would be integrated to advance mental health care, increasing collaboration across psychiatry, pediatrics, neurology, and obstetric programs, and responding to an urgent demand for outpatient mental health services. The project would also allow UCSF to begin to repurpose the existing Langley Porter Psychiatric Institute on the Parnassus campus, a building which must be demolished in the early 2020s in accordance with UCSF seismic safety plans and as part of a long-range plan to replace the Moffitt Hospital.

UCSF's financial planning had contemplated the expansion of these clinical services. Chancellor Hawgood explained that unlike the neuroscience services described in the previous item, mental health services do not generate profits. Nevertheless, the operating costs associated with this project would have an impact of less than two percent on UCSF's key financial ratios and an impact of less than one percent on the overall earnings before interest, depreciation, and amortization and on the net income of UCSF Health. Chancellor Hawgood stated his view that the strategic missions of UCSF's mental and behavioral health programs would compensate for this essentially flat financial forecast. These programs are critical to UCSF's larger population health strategy. No UCSF Health debt would be incurred to fund the design or construction. Payments for UCSF Health's share of the building occupancy costs would be paid annually to the campus from UCSF Health's operating budget.

Chancellor Hawgood outlined the overarching goals of UCSF's psychiatry program. Mental illness is a leading cause of disability worldwide. Patients face stigma and marginalization. There is a chronic underinvestment in facilities and programs locally and nationally. The Child, Teen and Family Center and Department of Psychiatry Building would communicate a strong statement by UCSF at this time. The Department of Psychiatry includes state-of-the-art programs in autism, eating disorders, mood and anxiety disorders, and sleep disorders and had achieved remarkable success in philanthropy for mental and behavioral health in recent years.

Regent Sherman asked about UCSF sites that would be repurposed. Chancellor Hawgood responded that the spaces vacated through this project and the project discussed in the previous item would be used for other programs in UCSF Health. Regent Sherman asked about the patient population's access to the new buildings. Chancellor Hawgood responded that public transportation to this site is better than to the Parnassus campus.

Advisory member Hernandez praised UCSF for its engagement in community mental health, which she described as an insatiable need and an enormous cost driver. She asked if this project would increase UCSF's capacity to provide care. Chancellor Hawgood responded in the affirmative. UCSF currently had capacity for approximately 40,000 psychiatry child and adult outpatient visits annually; in this new building that capacity would grow to about 80,000 visits. The new building would be a hub. Increasingly, UCSF was deploying its psychiatrists and behavioral health therapists in its general medical clinics. While the building would be the academic home for the

Department of Psychiatry, not all behavioral and mental health clinical visits would occur in this building.

Dr. Hernandez asked if the projected increase in capacity would be experienced both in pediatric and adult care, or more in one area than the other. Chancellor Hawgood responded that capacity would grow in both areas.

Upon motion duly made and seconded, the Committee approved the President's recommendation, Regents Lansing, Lozano, Makarechian, Napolitano, Reiss, and Sherman voting "aye."

The meeting adjourned at 2:45 p.m.

Attest:

Secretary and Chief of Staff