The Regents of the University of California

HEALTH SERVICES COMMITTEE
February 6, 2018

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

Members present: Regents Lansing, Makarechian, Reiss, and Sherman; Executive Vice President Stobo; Chancellors Block and Hawgood; Advisory members Dimsdale, Hernandez, and Lipstein

In attendance: Regent Park, Regent-designate Graves, Secretary and Chief of Staff Shaw, and Deputy General Counsel Nosowsky

The meeting convened at 1:30 p.m. with Committee Chair Lansing presiding.

1. **PUBLIC COMMENT**

A. Ms. Suzanne Paulson, professor in the UCLA Department of Atmospheric and Oceanic Sciences, noted that her research concerned air pollution, the built environment, and the location of pollution hot spots. She urged UC Health to endorse improvements in UC's bicycle infrastructure and to include active transportation as part of the University's health mission.

B. Mr. David Williams, professor of ophthalmology and neurobiology at the UCLA School of Medicine, asked the University to support and promote bicycling on campus. UCLA Transportation had made efforts to promote bicycling this year, but these efforts needed to be increased. Riding a bicycle on the Los Angeles campus can be dangerous, and many UCLA traffic lights do not respond to bicycles.

C. Mr. Zachary Gold, UCLA graduate student and member of the UCLA Bicycle Coalition, encouraged UC Health and the UC system as a whole to develop active transportation, which brings together and addresses health and air pollution concerns. UCLA had begun laudable initiatives, such as the UCLA Healthy Campus Initiative; this was a first step that incorporated some of these ideas.

D. Mr. Michael Cahn, visiting lecturer in the UCLA Department of History and representative of the UCLA Bicycle Academy, emphasized that active transportation would provide a solution to the environmental crisis of carbon emissions and the public health crisis of obesity and pre-diabetes. The University's Carbon Neutrality Initiative was a decisive commitment. He asked UC Health to adopt an active transportation policy. Inadequate bicycle parking facilities at UC Health premises and web pages with directions to UC hospitals project a message to staff and patients that everyone drives a car.

2. APPROVAL OF MINUTES OF PREVIOUS MEETING

Upon motion duly made and seconded, the minutes of the meeting of December 13, 2017 were approved, Regents Lansing, Makarechian, 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.]

Due to time constraints at this meeting, Executive Vice President Stobo stated that he would refrain from presenting remarks.

4. FORMALIZE APPROVAL OF BENCHMARKING FRAMEWORK FOR UC HEALTH POSITIONS RESULTING IN REVISIONS TO THE RESPECTIVE MARKET REFERENCE ZONES

The President of the University recommended that the Health Services Committee approve the new Benchmarking Framework revising the Market Reference Zones for UC Health positions in the Senior Management Group, recommended by the Regents Workgroup on UC Health Executive Compensation and approved by the Regents' Governance and Compensation Committee, as shown in Attachment 1.

[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.]

Committee Chair Lansing recalled that the Committee had already discussed this item in March 2017.

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

5. UC HEALTH UPDATE ON CAR-T CELL THERAPY

[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 introduced cancer biologist Alan Ashworth, President of the UCSF Helen Diller Family Comprehensive Cancer Center, Senior Vice President for Cancer Services, and Professor of Medicine. Before joining UCSF in 2015, Mr. Ashworth had served as the Chief Executive of the Institute of Cancer Research, London, and was perhaps best known for being part of the team that in 1995 identified the BRCA2 gene as a cancer susceptibility gene. Ten years later, he used a concept known as synthetic lethality to develop a new class of cancer drugs, PARP inhibitors, which had been successful in the

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

treatment of breast and other BRCA-dependent cancers. Mr. Ashworth was the inaugural head of the UC Cancer Consortium.

Mr. Ashworth began by noting that this discussion was motivated by genuine excitement about a new way of treating intractable cancers and questions about how this therapy would be paid for; he anticipated that this particular therapy would be just the beginning of many high-technology, transformative therapies that would also prove very costly. A new area of medical innovation was opening up, the ability to reprogram a patient's own cells to attack a deadly cancer. This kind of cell therapy presents a potential cure for patients facing lethal cancers and with no remaining care alternatives. Reimbursement ambiguity had resulted in slow adoption and treatment delays, and substantial financial exposure would be a challenge for providers of these very expensive therapies.

Immune cells patrol the human body for viruses, bacteria, and aberrant cells, and attack and kill those cells. Most people are not riddled by cancers because the immune system is poised at the right level, killing cancers as they arise without attacking the body's tissues. The new therapy takes immune cells, T cells, out of the body, inserts genes that recognize cancer, and then reinstates those cells in the body. These chimeric antigen receptor T (CAR-T) cells then seek, recognize, and kill cancer cells. This is an exceptionally powerful technology, demonstrated in a chart comparing outcomes in relapsed acute lymphoblastic leukemia cases for chemotherapy versus CAR-T therapy. A high proportion of patients treated with the CAR-T therapy had gone into remission, and these remissions appeared to be durable. It was not yet known if the therapy was absolutely curative.

CAR-T cells had limitations, and this therapy could be developed much further. These cells were limited to blood cancers of the B cell type. There were immense concerns regarding safety, in particular about off-tumor effects – these cells, when reinstated, attack normal tissues – and on-target effects: these immune cells are being hyper-activated and can have immune-like responses, such as cytokine storm and cerebral edema. There had been some deaths early in the development of this therapy when side effects were not properly managed. Management of side effects had improved, but this was part of the cost of delivering this therapy. The agents themselves were expensive, and the therapy can require long-term hospital treatment in intensive care units because of the cytokine storm effects. Cytokine Release Syndrome occurs in about 70 percent of patients.

Using combinatorial recognition programs, researchers at UCSF were now able to tune cells so they are much less liable to attack normal tissues. Cells would only kill cancer cells when they recognize two features. In standard T cell therapy, bystander cells and tumor cells are killed. In this new therapy, two features are recognized on the cell surface; the second is only engaged when first is recognized, through reprogramming the cell so that it produces additional weaponry to kill the cancer cell. When the cell goes on to recognize the bystander cell, the other tissues, it cannot "switch on." This was a very fine degree of control and the technology was in its early stages. Mr. Ashworth anticipated that the technology would become much more sophisticated.

There had been two approvals by the U.S. Food and Drug Administration for this therapy. Kymriah, by Novartis, had an invoice price of $475,000 and was indicated for childhood leukemia. Kite Pharma had produced a similar product, Yescarta, now approved for adult lymphoma. The Novartis product would likely also be approved soon for treating lymphoma. While there were not many cases of acute lymphoblastic leukemia, only about 600 in the U.S., there were many more adult lymphoma cases. The next approval for this therapy, likely to occur in the current or next year, would be for multiple myeloma. The UC system has been very active at all its medical centers with clinical trials for developing these treatments. Hospitals must go through an approval process in order to deliver this therapy. At UCSF, the children's cancer treatment was now licensed and being used. UCSF had treated four pediatric leukemia patients.

Mr. Ashworth explained that CAR-T cells are not a first line therapy, but used for relapse cases. In California, there are almost 900 annual cases of relapsed lymphoma, about 62 cases of relapsed acute lymphoblastic leukemia, and almost 600 cases of relapsed multiple myeloma. This would be a large number of patients, considering the cost of the therapy.

Mr. Ashworth discussed considerations for reimbursement. For commercially insured patients, UC Health expected that the reimbursement system would work reasonably well, and that UC would be paid at least what it spends on these patients. For Medi-Cal and Medicare, the situation was different. Medicare was lagging behind, but UC expected that it would catch up and cover the drug cost and overhead. For Medi-Cal patients, at this time, UC would lose a great deal of money on every patient. One patient in one of UC's clinical trials incurred more than $2 million in hospital charges. As the technology expanded, there would be many more patients.

Committee Chair Lansing asked for confirmation that insurance companies were paying for this expensive treatment. Mr. Ashworth responded that negotiations were ongoing, but he expected that UC would receive payment from insurance companies, and eventually also from Medicare.

UCSF Health Chief Executive Officer Mark Laret emphasized the extraordinary impact of this new therapy, but cautioned that the healthcare system was not attuned to multimillion dollar cases. UC Health was working with the State and was concerned that this therapy not be treated like an ordinary drug. He expressed optimism about Medicare reimbursement within a year, while securing reimbursement for Medi-Cal patients would take longer.

Advisory member Dimsdale asked about the University's risk exposure in UC Care and how many of these cases UC would likely see among its own insured population, in particular cases of multiple myeloma. Mr. Laret responded that he did not know the extent of this liability. This would be a significant question for every health plan. Dr. Dimsdale remarked that the University was experiencing more than one side of this development, as a provider seeking reimbursement from Medi-Cal, but also as an insurer.

Regent Reiss asked if most clinical trials were occurring with children. Mr. Ashworth responded that this was the case for the therapy approvals. He anticipated that this therapy would be applied to solid tumors in three to four years. The nature of care was changing. Myeloma has traditionally been treated with bone marrow transplantation, but this new therapy might become the preferred form of treatment. The discussions about reimbursement would lag behind development of the therapy and treatment of patients, and large costs would be incurred in the meantime. The University absolutely does not want to turn away a child with a curable cancer. Mr. Ashworth observed that these were not insurmountable problems. The cost for this and other new therapies being developed would be in the high hundreds of thousands of dollars. Society and the healthcare system must grapple with the question of how to pay this cost, and how to pay the cost for those who cannot afford it.

Committee Chair Lansing expressed the hope that this therapy would not just treat disease, but cure patients. If patients were not cured, the progression of the disease and its treatment also become very costly. She stressed that the University cannot turn any patient away due to inability to pay. Regent Reiss asked if situations had arisen of patients who were treated at UC but who could then not afford the medications they were prescribed. UCLA Health President Johnese Spisso responded that medical centers, in evaluating a patient for a procedure such as solid organ transplantation, must ensure that the patient can obtain the medications and remain compliant with the regimen. There is a careful screening process for patients. Mr. Laret added that the medical centers, as self-supporting enterprises, have limited funds and must make decisions about which patients receive certain treatments. UC Health's goal is to treat all the patients it can. At a certain point this becomes a societal question, the question of how much the wider society is willing to pay to allow UC to provide life-saving treatments. If UC Health were to secure reimbursement of only 50 percent from Medi-Cal for this therapy, this would be a terrible outcome; the University would lose money on every patient and it was not clear how UC would make up for this loss.

Committee Chair Lansing asked if there were any possibility that the cost of this treatment would be reduced. Mr. Ashworth responded that some competition was emerging, but in the pharmaceutical industry, this area had not been open to much competition in pricing. The pharmaceutical industry sets prices, and there was no evidence of costs being driven down; even for generic drugs, costs are not driven down by much.

Chancellor Block asked if the great cost was the cost of the initial development of the therapy or the cost of customized treatment for each patient. Mr. Ashworth responded that development of the therapy was the most obvious immediate cost. He discussed a chart with information on four patients who had been treated with Kymriah. Each patient had a different experience, with different costs. Patient 2 had been treated as an outpatient, whereas Patient 3 had a 31-day inpatient stay in the pediatric intensive care unit, at much greater cost. Side effects of the treatment can be life-long. The cost would vary by individual, but it was currently estimated that the average cost would range between $500,000 and $1 million per patient.

Advisory member Lipstein asked if there were any factors for Patients 2 and 4 that would explain a difference in the effectiveness of therapy. Mr. Ashworth responded that no obvious factor was known at this stage. The number of patients was too small. A study had just been published based on 100 patients, and even this was too small a sample to draw conclusions from. Over time, researchers and doctors should be able to predict which patients would have more acute side effects.

Committee Chair Lansing observed that advocacy by groups of people affected by cancer can be effective. Patient advocacy groups had had an effect on the pricing of Receptin.

Regent Park stated that the underlying economics in this situation were troubling and might worsen over time. The State would also be grappling with this issue, which might have an impact on State budget line items for UC. She asked how a better economic model might be developed for this therapy. Mr. Laret responded that UC's medical centers are self-supporting and do not receive line item funding from the State. This was a matter of balance, generating enough operating margins from commercially insured patients, who bring in more money than it costs UC to treat them, to support treatment for Medi-Cal patients. UC medical centers also had to generate sufficient margins to support education and research at the schools of medicine. The State might have to choose between funding this therapy and other priorities.

Committee Chair Lansing acknowledged that the high cost was a serious and immediate problem, but suggested that emerging competition might bring down the cost. Public outrage at drug companies is enormous when the existence of promising new therapies and high costs become known.

Regent Sherman asked if the price of the therapy was the same outside the U.S. Mr. Ashworth responded that the therapy had not yet been approved by European organizations. Based on previous experience, it would be more expensive in the U.S. than elsewhere. Ms. Spisso added that UCLA had worked with Kite Pharma and the Yescarta product. Kite Pharma had established a foundation that can assist patients without financial means. UCLA's experience of working with Kite Pharma had been positive, and there was some infrastructure to navigate coverage for patients. Committee Chair Lansing observed that Kite Pharma was a unique company, founded by a UCLA Health Surgical Director and researcher. The initial investors returned a certain percentage of their earnings to establish this foundation to ensure that this treatment would be available to all patients.

Mr. Lipstein stated that this was exciting new pharmaceutical technology with major financial implications. He projected that Medicare coverage would be the most significant financial factor for UC Health in the 2020s, and estimated that for the five medical centers, the government "add-on" payments for Medicare, such as direct costs of medical education, indirect costs, Disproportionate Share Hospital funding, the capital pass-through program, and outlier payments, all added together, would exceed the operating margin of UC Health or even the UC system. This would occur between 2020 and 2030, when 80 million people would become eligible for Medicare. If Medicare covered the cost of

CAR-T cell therapy, it might be from deficit financing. Mr. Lipstein suggested that the Committee have a major discussion about Medicare funding during this year or in 2019.

Regent-designate Graves asked if UC Health budgets in advance for patients who cannot afford a treatment or reconciles this later. Mr. Laret responded that UCSF does not have such a fund to draw on. Because this is a new treatment and a limited number of patients, UCSF had made the decision to cover them. UCSF would try to find savings in other areas to cover this cost. This was only a short-term solution. In the long term, society needed to find a way to cover this cost or to reduce it; UCSF could not absorb this cost.

Committee Chair Lansing reiterated that advocacy by patients and hospitals, directed at the drug companies, was necessary. Mr. Ashworth observed that even if drug companies were to provide this therapy free of charge, the hospitals would still have the large-scale costs of delivering the care, which are equal to the cost of the therapy. This was a larger problem, and no single group had control over the whole issue. So far, in response to advocacy, pharmaceutical companies had not reduced their overall costs.

Regent Reiss asked that the Committee receive a presentation at a future meeting on projected Medicare costs and reimbursement rates. It would be helpful for the Committee to see how the situation might worsen as more people are enrolled in Medicare, reimbursement rates are reduced, and the cost of providing care and the cost of drugs increase. Executive Vice President Stobo responded that such a discussion would be held.

Committee Chair Lansing anticipated that more treatments like the CAR-T cell therapy would be developed and UC Health would be facing the same challenges. She asked that the Committee be kept apprised regarding the status of reimbursement for this therapy.

Dr. Stobo stressed that the CAR-T cell treatment was only one among 20-odd other such therapies. If UC Health wished to be able to continue this work and to treat all patients before it could have an influence on health policy in the U.S., an extremely difficult task, UC must ensure it was doing all it can to keep overall costs down and maintain a sufficient operating margin.

6. **AFFILIATION FOR ADVISORY SERVICES IN CHINA, LOS ANGELES 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.]

UCLA Health Sciences Vice Chancellor John Mazziotta recalled that in October 2017, UCLA had made a presentation about its interest in entering into a three-way agreement to design, construct, and operate two hospitals in Guangzhou, People's Republic of China. UCLA Health would have a strategic alliance and a service agreement to advise the other two parties to the agreement on the process of developing the hospitals. One of the partners would be Medpoint Health Partners, a U.S.-based company that would be responsible for day-to-day operations and management. The owner of the hospitals would be Guangzhou

R&F Properties Co., Ltd., a China-based property developer that would invest all funds and develop the hospitals. If successful, this project could become a new revenue source for UCLA Health.

Dr. Mazziotta outlined the value of international projects. An important mission of the University is to support the development of health systems for underserved populations. International projects provide opportunities for trainees, research, and sharing of clinical best practices. Efficiency and financial benefits can be derived from these projects through shared use of high-technology equipment, new sources of revenue, new sources of patients, trainees, and faculty, and international academic and corporate collaborations.

UCLA was mindful of the risks of international projects and was working to manage the risks in this arrangement. International projects were common across UC, and all UC Health campuses had projects in other countries. Many projects are fairly informal, while some are governed by memoranda of understanding. UC shares its faculty time and expertise, most often without being compensated. Under the proposed agreement in China, UCLA Health would be compensated for all its costs and the value of its brand.

Dr. Mazziotta presented information for UC Health projects under way in other countries by category of project focus, whether education, research, clinical care, or patient marketing. Research projects were the most common type, and most of these projects were in Africa or Asia. The three campuses pursuing the greatest number of international health projects were UCSF, UCLA, and UC San Diego, and there were more than 1,200 different UC Health projects under way in other countries.

The proposed project in China was unique in being a pure service agreement. UCLA Health would not make any investment and would not own, operate, or have an equity position in these hospitals, but would act in an advisory capacity. The agreement pertained to two hospitals, but could be expanded to more hospitals. The presence of a third-party U.S. partner in this arrangement also made it unique. Medpoint Health Partners had experience with developing and managing hospitals in China.

Regarding capacity to take on this project, UCLA Health believed that the endeavor would not inhibit its activities in Los Angeles, but provide a new and non-traditional source of revenue. UCLA Health wished to share best practices in a collaborative way, but wished to be compensated for this activity, as it would be under this agreement.

Chancellor Block observed that there was a demand in China for high-quality, Western-style hospitals. This was an opportunity to test whether UCLA Health can be helpful and benefit from relationships with new Chinese hospitals. Guangzhou R&F Properties would like to develop about ten hospitals across China, beginning with two hospitals in Guangzhou. Chancellor Block viewed this project as an instance of positive global engagement for UCLA, and he hoped that this relationship would yield revenue, new patients, and opportunities for UCLA doctors and students. He acknowledged that there were risks. UCLA must protect its powerful and valuable brand, and he believed that there was sufficient protection in this agreement for the UCLA brand.

Regent Makarechian asked if there were financial projections for this endeavor. Dr. Mazziotta responded that these were confidential.

Regent Makarechian asked about the consequences if the Chinese partner were to default on the agreement. This was not a joint venture partnership. UC Health was passing on knowledge and best practices, and he expressed concern and skepticism about reaching a satisfactory deal in China. UCLA Health President Johnese Spisso responded that this arrangement would be a service agreement. UCLA would be paid for services in consultation as they are delivered, on a pay-as-you-go basis, and would receive a net profit for this work. Medpoint Health Partners would operate the facilities. If at any time UCLA needed to sever the relationship, it could do so and would have already been reimbursed for the work provided.

Regent Makarechian suggested the model of large hotel companies that partner with developers in other countries. The hotel companies retain control, including control over customer information, keep a portion of the profits, and charge a fee over the revenues. Dr. Mazziotta explained that Medpoint Health Partners would be in that position, as manager of the property. The use of the UCLA brand was still being negotiated and would be a collaborative arrangement. The brand would only be used for marketing purposes, not associated with patient care or finances, and it would not appear on individuals' badges or uniforms. It might be possible for UCLA to withhold its brand if standards were not achieved and reinstate the brand when standards were achieved. This was still under negotiation.

Regent Makarechian countered that Medpoint Health Partners needed UCLA's brand and expertise. In protecting its brand in this arrangement, UCLA Health should follow the example of a reputable international hotel company. Dr. Mazziotta asked if the hotel companies are equity holders in the hotels. Regent Makarechian responded in the negative. Most often, hotel companies would pay a fee up front rather than equity. They might choose to participate in equity after examining market conditions. The question of equity is separate from the management contract. Dr. Mazziotta responded that he could discuss this model further with Regent Makarechian, and to what degree elements of this model could be included in this arrangement.

Regent Makarechian remarked that the local developer for a hotel company would receive a significant penalty for violating a contract. He expressed concern that the partner in China would seek a means of ridding itself of UCLA and ending the agreement after a few years, after having acquired UCLA's knowledge and expertise.

Regent Reiss suggested that the fees being paid to UCLA might be sufficient reimbursement even in such a situation, unless UCLA were sharing intellectual property with the partner.

Regent Makarechian emphasized that UCLA would be providing a great deal of assistance in setting up these hospitals and transmitting a great deal of knowledge.

Regent Reiss stated that global collaborations are good for the University and contribute to its positive reputation. She asked if UCLA had considered negotiating not only for fees, but also for revenue and equity, or if UCLA felt that it was not offering enough to receive revenue and equity in return. Ms. Spisso responded that from the outset, UCLA was not interested in owning or operating the facilities or having an equity position. The University is looked upon worldwide as a resource to provide healthcare expertise, as demonstrated by the large number of international health projects that UC is involved in. For some time, UCLA faculty have been sharing information and volunteering, activities that can be taxing for the organization. In its dialogue with Medpoint Health Partners, UCLA Health discussed best practice models that would cover UCLA's costs, provide additional infrastructure, and provide at least fair market value for the work UCLA performs. UCLA was interested in obtaining recompense for the extensive knowledge UCLA already shares on a volunteer basis. UCLA Health staff were interested in this project; information technology staff were excited about the prospect of a site visit in China.

Regent Reiss asked about UC liability under Chinese law, the possibility that Chinese patients could sue UC as well as the Chinese partner in case of an adverse medical outcome, and financial risk in this area. Dr. Mazziotta responded that this was a real financial risk, although UCLA felt that the risk was remote and that there were sufficient safeguards in the agreement, including reciprocal indemnification.

Regent Makarechian asked if this indemnification was being provided by the Chinese partner or the U.S. partner. Deputy General Counsel Rachel Nosowsky explained that all parties to the agreement would be responsible for their own actions.

Regent Makarechian cautioned that in case of a dispute, the party with better connections in China would receive the more favorable ruling. The University must keep this in mind.

Regent Park asked if this partnership was unique due to the brand issue. Dr. Mazziotta responded that he did not know about brand issues for the more than 1,200 UC Health projects abroad. In this case, having a U.S.-based company as a third partner was a new aspect that had not been encountered before.

Regent Park asked if UC Health had any other co-branding agreement with a hospital in another country. Chancellor Hawgood responded that UCSF did not have such an agreement.

Regent Park asked if the revenue received by UCLA would account for consulting activities and reflect the value of the brand. Dr. Mazziotta responded that the amount of revenues would reflect time and expense put into the project and more, because of the brand value.

Regent Park asked if the value of the brand was quantified. Ms. Spisso responded that this issue was addressed in developing the agreement in consultation with Medpoint Health Partners.

Regent Park stressed that these hospitals would use the UCLA brand for outreach and marketing, above and beyond UCLA employees' time and effort spent on this project. Ms. Spisso responded that this would occur under mutually agreed-upon circumstances which had yet to be determined; UCLA would have control over this. Regent Park asked if this aspect of the agreement would be reported on at a future meeting. Ms. Spisso stated that this information could be provided.

Regent Park asked about the nature of the new hospitals; for example, if this would be concierge medicine. Ms. Spisso responded that the hospitals would not engage in concierge medicine. The goal was to improve the quality of patient care in China. Medical centers in China, by relying on the expertise of academic medical centers like UCLA, could continue to improve the quality of care and benefit from continuous learning opportunities.

In response to another question by Regent Park, Dr. Mazziotta and Ms. Spisso confirmed that although the brand would extend to the entire hospital operations, UCLA employee activities would focus on quality of care and training.

Executive Vice President Stobo and Committee Chair Lansing suggested that any Regents with concerns or questions about the proposed affiliation discuss them with Dr. Mazziotta and Ms. Spisso. Committee Chair Lansing recalled that UCLA did not need the Regents' approval to pursue this affiliation and thanked UCLA for discussing this matter openly and transparently.

Advisory member Lipstein remarked that two essential issues might best be discussed separately. The first was the consulting arrangement and the fee for service and expertise. The second issue was the brand monetization strategy. Brand monetization would attract the attention of State government, and therefore the two issues should be separated.

Regent Reiss remarked that in this affiliation, UCLA would be paid for work it has provided for free in the past. Committee Chair Lansing concluded that if this arrangement were economically fruitful, it would be of great benefit to UCLA Health.

The meeting adjourned at 2:55 p.m.

Attest:

Secretary and Chief of Staff

Attachment 1: Proposed Market Reference Zones

Title	Incumbent Data as of December 1, 2017		Entity	Market Base Salary Data Effective July 1, 2017				
	Name	Salary		P25	P50	P60	P75	P90
Executive Vice President	Stobo	$633.8	UCOP	$576.0	$780.2	$816.1	$869.8	$1,118.9
CEOs								
Chief Executive Officer	Laret	$1,072.8	UCSF	$1,051.8	$1,215.2	$1,322.7	$1,484.0	$1,651.6
Chief Executive Officer	Spisso	$1,028.6	UCLA	$1,051.8	$1,215.2	$1,322.7	$1,484.0	$1,651.6
Chief Executive Officer	Rice	$904.8	UCD	$809.0	$993.1	$1,075.7	$1,199.5	$1,358.9
Chief Executive Officer	Maysent	$880.8	UCSD	$760.7	$882.8	$967.9	$1,095.5	$1,250.0
Chief Executive Officer	Federoff	$824.0	UCI	$679.5	$844.4	$904.9	$995.7	$1,199.5
COOs								
Chief Operating Officer	Vacant	$0.0	UCSF	$620.5	$672.6	$745.8	$855.7	$1,026.7
Chief Operating Officer	Vacant	$0.0	UCLA	$620.5	$672.6	$745.8	$855.7	$1,026.7
Chief Operating Officer	Simmons	$592.3	UCD	$502.2	$589.4	$625.4	$679.5	$842.9
Chief Operating Officer	Vacant	$0.00	UCSD	$449.5	$556.6	$594.9	$652.2	$751.2
Chief Operating Officer	Gannotta	$600.0	UCI	$381.5	$504.6	$539.7	$592.3	$752.4

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Title	Incumbent Data as of December 1, 2017		Entity	Market Base Salary Data Effective July 1, 2017				
	Name	Salary		P25	P50	P60	P75	P90
CNOs								
Chief Nursing Officer and Assistant Dean in the School of Nursing	Grimley	$391.4	UCLA	$378.7	$407.7	$434.1	$473.5	$510.4
Chief Nursing Officer	Marsh	$358.4	UCD	$332.0	$378.7	$396.5	$423.1	$477.0
Chief Nursing Officer	Patton	$315.0	UCI	$319.3	$329.3	$346.3	$371.9	$410.8
CMOs								
EVP, Physician Services and Vice Dean-Clinical Affairs	Adler	$648.9	UCSF	$584.2	$645.7	$696.0	$771.5	$1,002.2
Chief Medical Officer	Kirk	$546.8	UCD	$472.0	$509.5	$534.6	$572.3	$677.5
Chief Medical Officer	Scioscia	$464.9	UCSD	$429.1	$492.8	$518.1	$556.1	$622.1
Chief Medical Officer	Wilson	$470.0	UCI	$439.0	$483.5	$498.5	$520.9	$583.4
CIOs								
Chief Information Officer	Vacant	$0.0	UCD	$414.3	$435.6	$459.8	$496.0	$564.1
Chief Information Officer	Podesta	$421.8	UCI	$363.7	$404.0	$429.9	$468.6	$502.5
CFOs								
Chief Financial Officer	Strickland	$736.0	UCSF	$567.0	$692.5	$730.4	$787.1	$900.6
Chief Financial Officer	Staton	$662.9	UCLA	$567.0	$692.5	$730.4	$787.1	$900.6
Chief Financial Officer	Sial	$574.8	UCI	$376.5	$499.7	$529.3	$573.8	$701.2
Chief Financial Officer	Maurice	$466.0	UCD	$477.5	$554.9	$591.4	$646.2	$808.9
Chief Financial Officer	Donaldson	$373.9	UCSD	$423.5	$525.0	$545.0	$574.9	$697.7

Proposed Market Reference Zones

Title	Incumbent Data as of December 1, 2017		Entity	Market Base Salary Data Effective July 1, 2017				
	Name	Salary		P25	P50	P60	P75	P90
UCOP								
Associate VP, Chief Medical Officer - Self Insured Plans	Louie	$346.8	UCOP	$290.3	$319.9	$332.3	$351.0	$494.9
Medical Director, Student Health Insurance Plan	Buchman	$397.9	UCOP	$203.6	$273.5	$301.8	$344.2	$399.5
Associate VP, UC Health	Nation	$269.7	UCOP	$174.9	$219.7	$262.2	$326.0	$428.4
Associate VP, Chief Strategy Officer, UC Health	Engel	$385.0	UCOP	$384.0	$520.2	$544.0	$579.9	$746.0
Chief Legal Counsel for Health Services	Nosowsky	$303.6	UCOP	$413.6	$486.5	$531.4	$598.7	$725.9
Chief Procurement Officer	Vacant	$0.0	UCOP	$281.7	$332.8	$348.9	$373.0	$392.0
Chief Transformation Officer	Vacant	$0.0	UCOP	$361.0	$459.8	$481.4	$513.7	$608.2
Other Roles								
SVP, Clinical Practice and Ambulatory Care	Vacant	$0.0	UCSD	$295.1	$406.5	$448.9	$512.6	$522.7
SVP UCSF Health Affiliates	Vacant	$0.0	UCSF	$389.5	$476.8	$492.8	$516.8	$583.7
SVP, Adult Services/President-UCSFMC	Antrum	$697.0	UCSF	$504.5	$597.9	$651.4	$731.7	$863.2
SVP, Children's Services/President of Benioff Children's Hospital	Anderson	$946.0	UCSF	$625.2	$730.8	$779.1	$851.5	$994.6
Chief Clinical Officer	Baggett	$390.1	UCSD	$250.3	$319.1	$354.1	$406.4	$458.9
VC, Business Development, Innovation and Partnerships	Selick	$420.0	UCSF	$323.1	$392.1	$408.4	$432.8	$581.2
Chief Administrative Officer, Santa Monica	Watkins	$404.7	UCLA	$304.9	$364.8	$383.1	$410.5	$487.3