The Regents of the University of California

HEALTH SERVICES COMMITTEE
November 12, 2024

The Health Services Committee met on the above date at the UCSF–Mission Bay Conference Center, San Francisco campus and by teleconference meeting conducted in accordance with California Government Code §§ 11133.

Members present: Regents Batchlor, Chu, Makarechian, Pérez, Sherman, and Sures; Ex officio members Drake and Reilly; Executive Vice President Rubin; Chancellors Hawgood, Khosla, and Wilcox; Advisory members Marks and Ong

In attendance: Regents Anguiano, Beharry, Guber, Leib, and Pack, Regents-designate Brooks, Komoto and Wang, Faculty Representatives Cheung and Palazoglu, Staff Advisors Emiru and Frías, Secretary and Chief of Staff Lyall, Deputy General Counsel Stayn, Executive Vice President and Chief Financial Officer Brostrom, Executive Vice President and Chief Operating Officer Nava, Interim Senior Vice President Turner, Vice President Kao, Chancellor May, Interim Chancellor Hunt, and Recording Secretary Johns

The meeting convened at 1:20 p.m. with Committee Chair Pérez presiding.

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

Upon motion duly made and seconded, the minutes of the meetings of July 16, August 14, and the joint meeting of the Governance Committee and the Health Services Committee of July 17, 2024 were approved, Regents Batchlor, Drake, Makarechian, Pérez, Reilly, and Sherman voting "aye."[1]

2. **PUBLIC COMMENT**

Committee Chair Pérez 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. Tricia Geurtsen charged the Regents, Governor Newsom, and President Drake with genocide and ongoing *nakba* (an Arabic word meaning "catastrophe"). Faculty, staff, and students were concerned about what Ms. Geurtsen described as UC's complicity in ongoing U.S.-backed genocide, settler colonialism, ethnic cleansing, and apartheid in Palestine. The University had suppressed its own workers and students who seek justice for Palestine, a future for the Palestinian people, and a world free from imperialist aggression. The University had long benefited from the occupation of stolen, unceded indigenous lands and investment in the military-

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

industrial-academic complex. In her view, UC had contributed to the crimes of genocide through its financial ties to Israel and unethical investments in war industries.

B. Christine Hong continued Ms. Geurtsen's statement. UC investments included surveillance technologies and other corporate instruments of violence. She asserted that, through institutional cooperation and agreements with Israeli universities, UC materially contributed to and facilitated ongoing *nakba* and genocide in Palestine. By facilitating research funded by the U.S. government and corporate war industries, UC leadership has played a central role in imperialist devastation, human suffering, and environmental ruin around the globe, including in Palestine. UC leadership has accepted funding from Zionist institutional and individual donors, including some who have funded organizations that smear, harass, and threaten UC students, staff, and faculty who have spoken out against genocide.

C. Elena Salazar, parent of a UC Berkeley student, expressed concern about drug spiking and predatory drug crimes, which were affecting college students nationwide. All campuses should have drug testing kits, as articulated in State Assembly Bill (AB) 1524. Many assaults involve drugs that incapacitate victims, yet these crimes often go unreported. These test kits could be integrated into UC's health services, similar to fentanyl test strips. By adopting this measure, the Regents can prioritize student safety and set a strong precedent in addressing drug-related offenses.

D. Namrata Deepak alleged that donor influence has chilled academic freedom and free speech at UC, contributing to the epistemological erasure and social death of the Palestinian people, and that UC leaders have normalized the settler-colonial, apartheid, and genocidal Israeli state, perpetrated anti-Palestinian racism, and weaponized false claims of antisemitism in order to stifle protest, criticism, and study of genocide. UC leaders have waged a campaign of persecution, repression, and intimidation against students, workers, and community members in order to silence political dissent in the face of genocide while approving the purchase of military-grade weapons to further such oppression. UC leadership has remained silent in the face of ecocide, the destruction of the teaching and healthcare systems, and the murder of healthcare and humanitarian workers in Gaza.

E. Michael Harris, physician and member of the American Jewish Medical Association, asked the University to take three steps to support the Jewish community at UCSF. UCSF and every UC medical center and location should explicitly affirm that Jews and Israelis are welcome as patients, staff, students, trainees and faculty. UCSF must enforce existing policies regarding political statements expressed in speech, dress, and on social media, and it must do so in a viewpoint-neutral fashion. UC should adopt the Jewish community's mostly widely supported definition of antisemitism, the International Holocaust Remembrance Alliance's definition, and should follow the request of the California Legislature in

AB 2925 such that any anti-discrimination training specifically addresses discrimination against the five most targeted groups in the state.

F. Melanie Ramiro, President of the UC Riverside Staff Assembly and a delegate of the Council of UC Staff Assemblies (CUCSA), spoke on behalf of UC staff members who rely on annual salary increases to manage the ever-increasing cost of living in California. While the University aimed to attract and retain top talent to position itself as an employer of choice, the more than 3,000 staff openings systemwide showed that UC was falling short of this goal. In recent years, salary growth for non-represented staff has fallen significantly behind that of represented employees. This disparity has widened as the cost of living in California has increased by 20 percent and the cost of home ownership by 22 percent since 2020. This placed an especially heavy burden on non-represented staff, who did not have pre-negotiated merit increases. UCR staff were 69.5 percent people of color and 66.5 percent women. The current situation perpetuated an undervaluing of the contributions of women and people of color in the workforce. Ms. Ramiro asked the Regents to take a stand for a fair and equitable approach to compensation that reflected the value of every employee's contribution to the University's success.

G. Kristen Ikeda Yoza, UC Santa Barbara staff member and CUCSA delegate, reported that her salary was 27 percent below market rate. Increases in the cost of housing, health care, and general living expenses were significantly affecting staff across the UC system. CUCSA requested that UC give consideration to ensuring equity among staff members when making decisions regarding salary increases. Housing costs in Santa Barbara were high, and the rental cost of a one-bedroom apartment would equate to 60 percent of Ms. Ikeda Yoza's take-home pay. Purchasing a home was completely out of the question for her as the median home price in the area was over $1.7 million. She urged the Regents to support salary increases for non-represented staff.

H. Maya Hilmi, a Palestinian student at UC Berkeley, reported that 36 members of her family were killed in Gaza at the hands of Israel Defense Forces soldiers and the Israeli state. She asked the Regents to take a stand against the ongoing genocide in Palestine and averred that the majority of the campus community at UC Berkeley supported divestment from war, occupation, and genocide. The Associated Students of the University of California (ASUC) and the UCB Graduate Assembly had both pledged to pull their funds from the UC Berkeley Foundation if it failed to divest from companies complicit in these crimes. Over 16,600 alumni have vowed to withhold donations until the University divests. Ms. Hilmi stressed that this was not just student opinion but a collective cry for justice. She exhorted the University to divest from weapons manufacturers and genocide enablers.

I. Kaneesha Goyal charged the leaders of UCSF and the UCSF Foundation Board of Directors with complicity in the ongoing genocide of the Palestinian people. As the only UC campus wholly focused on health, health care, and health professions, UCSF has a particular ethical responsibility to uphold the sacred healthcare worker

oath to do no harm and to protect humanity. In the current situation, UCSF administrative leaders have failed to carry out UCSF's stated mission to advance health worldwide and to honor the Hippocratic Oath. Research and lived experience substantiated the direct connection between past and current settler colonialism, racism, and imperialism on the one hand and the health of communities most affected by these structures on the other. The reciprocity between indigenous land and peoples was foundational to the health of humanity and the planet.

J. Steve Ravellette, member of SafeBears, a nonprofit organization dedicated to making UC Berkeley safer for students, noted that AB 1524 was a new law to combat drink spiking on college campuses. The law, which would take effect in July 2025, requires California State University and community college districts to provide drug testing devices free of charge at campus health centers with prominently displayed notifications. SafeBears encouraged UC and other higher education institutions to implement these measures as well, thus underscoring their commitment to student safety and health.

K. Elizabeth Milos, member of University Professional and Technical Employees (UPTE) Members for Palestine, declared that UCSF was a land grant institution that profited from genocide on its land, denied this land to the Ramaytush Ohlone people, and was complicit in the murder of indigenous people and ecocide in Palestine. She alleged that the UCSF administration upheld Zionism, a white supremacist ideology, and perpetrated anti-Palestinian racism locally and globally. At a moment when over 1,000 Palestinian healthcare workers have been killed and hospitals, the healthcare system, and health professional schools in Gaza have been decimated, UCSF leaders have attacked and endangered those who decry this violence.

L. Leor Weinberger, a Distinguished Professor at UCSF, announced that he had decided to leave UCSF because of antisemitism. Two days after the Hamas attack on Israel in October 2023, the massacre of women and children, and kidnapping of friends of Professor Weinberger, an email was sent to his entire UCSF institute by a UCSF graduate student which claimed that the resistance attacked Israeli army positions, no civilians were targeted, no rapes occurred, and all deaths were the responsibility of the Zionist entity. The email frightened Professor Weinberger's trainees. While the email was bad, the lack of response by the UCSF administration was worse. The University failed to comply with its own code of conduct, and if it continued to fail to apply this code, more talent would leave the University.

M. Nadra Lisha, UCSF Assistant Professor, stated that she had observed a concerning rise in antisemitism at UCSF as well as reluctance by leadership to address incidents. She recounted a troubling experience at a regular monthly meeting that she is required to attend. One of the attendees had prominent "Free Palestine" sticker with a flag on it. Given the use of this slogan by those who call for the elimination of Israel by any means necessary, many Jews see this as a call to expel the eight million ethnic Jews who live in Israel. While Ms. Lisha's supervisor was

very empathetic, the campus could take no action. Creating a safe, inclusive environment for all members of the UCSF community was an important goal, and this effort needed to include Jewish UCSF community members.

N. A male speaker alleged that UCSF leadership has violated the healthcare worker oath to serve humanity and its own UCSF physician declaration by failing to decry genocide, the murder and torture of healthcare workers, and the destruction of healthcare and health professions education systems in Palestine; UCSF leaders have attacked the free speech and academic freedom of UCSF students, staff, and faculty who have sought to fulfill their oath. These attacks included defamatory campaigns and the suspension and firing of those who have spoken up for the freedom of Palestine. UCSF has withheld aid to Palestinians who were suffering the impacts of climate catastrophe, mass starvation, the spread of infectious diseases, severe trauma, and other health calamities. He asserted that, by investing in the Israeli state and corporations and procuring medications, equipment, and services from Israeli companies, UCSF was aiding and abetting occupation and genocide.

O. John Burner continued the previous speaker's statement, contending that UCSF sustained Israeli occupation through its institutional collaborations with Israeli universities while refusing parallel investment in Palestinian institutions. He claimed that UCSF has consistently and falsely equated criticism of Israel and Zionism with antisemitism, a practice that endangered Palestinians, Arabs, Muslims, anti-Zionist Jews, and all marginalized and oppressed communities while declining to investigate complaints of anti-Palestinian racism, harassment, and death threats. Mr. Burner criticized the UCSF administration for accepting $1.15 billion from the Helen Diller Family Foundation, which he described as an explicitly Zionist foundation that supports right-wing hate groups.

3. **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 Rubin expressed pride in UC Health's release of its Report on Community Benefits for 2022–23, which would be discussed later in the meeting, and highlighted an important contribution in education, the Programs in Medical Education or PRIME programs. He recalled that the first UC PRIME program had been launched at UC Irvine in 2004. PRIME programs respond to the statewide need to increase healthcare delivery in under-resourced areas and to expand the number of physician-leaders committed to addressing healthcare disparities. The first program, Program in Medical Education for the Latino Community (PRIME-LC), provides training to those students whose career mission is to serve the needs of Latino patients from the vantage point of clinical care, research, and leadership at the highest levels. Drawing on this success, there were now ten UC PRIME programs, each with a specific area of focus that was determined by the needs of patient populations and the surrounding community. Other PRIME

programs seek to improve rural health, indigenous health, healthcare access in urban under-resourced areas, healthcare access in the San Joaquin Valley, African, Black, and Caribbean health, leadership and advocacy, and health equity. With dedicated curricular content and faculty mentorship, UC PRIME students are exposed to population-focused clinical training and research experiences beginning as early as their undergraduate years.

The results of the PRIME programs were impressive. More than half of all PRIME graduates have completed residency training in primary care and other designated workforce shortage specialties such as psychiatry, general surgery, and emergency medicine. Nearly three-quarters of PRIME graduates go on to train in residency programs in California or continue practicing in the state. In 2023, 84 percent of PRIME students were from groups underrepresented in medicine and over half of PRIME graduates who have completed their training serve under-resourced communities.

Dr. Rubin noted that the UC Health annual financial report would be presented the following day in the meeting of the Finance and Capital Strategies Committee. UC medical centers are the engines of a broad set of healthcare services and programs that extend well beyond UC's hospital walls. While these financial reports focused on medical center performance, it was important to note that each campus has evolved from a standalone medical center to an integrated health system, providing access to a comprehensive array of services. All the medical centers were self-sustaining; their revenue must be sufficient to support their own operations as well as fund the broader University mission of research, education, and clinical excellence along with a strong commitment to the communities in which they reside. This included subsidizing care for vulnerable populations and the uninsured, advancing health equity and behavioral health initiatives, addressing growing community demand for care, training the next generation of clinicians, and funding the construction and maintenance of facilities.

Each medical center operates in a unique market, and this makes it difficult to compare them to each other. Nevertheless, certain common themes have emerged, and these would help to reshape UC Health and to better position UC's health plans and services to meet priorities for the State of California and its residents. This year was one of transformation, as each medical center cemented and furthered its role as an essential part of California's health safety net. Each location has worked to increase capacity while optimizing its community footprint and prioritizing patient-centered improvements for complex and coordinated care.

The mission of public service remained central to UC Health. Over two-thirds of UC patient volumes were Medicare and Medi-Cal enrollees, reflecting UC Health's commitment to providing care for all Californians, and particularly those with the greatest need. UC Health was also acutely aware that many California residents continued to have difficulty in accessing health care due to limited statewide capacity, including at UC's own medical centers. Over the last five years, visits to UC outpatient facilities have grown by 41 percent, surpassing 10.7 million annual visits this year. Annual inpatient discharges have increased by 13 percent, exceeding 190,000 discharges this year, including the growth seen through recent acquisitions of facilities throughout the state. With these acquisitions,

the medical centers were linking community care professionals and facilities with the advanced resources of academic medicine. This was positioning UC to expand access and offer more seamless care that addresses patients' basic, chronic, and complex health needs closer to home.

Amidst this change, and facing headwinds such as inflation, reimbursement challenges, and the rising cost of labor, supplies, pharmaceuticals, and capital equipment, the overall financial performance of UC medical centers has remained stable. The resilience of the UC medical centers was a testament to the commitment to continuous performance improvement, the focus on the core mission, the exceptional quality of care UC teams provide, and the professionalism and dedication of UC faculty, staff, and trainees. Ultimately, UC Health's financial stewardship would provide the flexibility to explore further development opportunities across other areas of the state, ensuring that high-quality care is accessible to more Californians in regions where UC Health campuses are located.

The University seeks to earn the trust of its patients and communities every day. Californians were showing that they value UC Health's quality and commitment to its mission and would like to see more of what UC offers. UC Health was responding. Through increased and strategic investments in education, research, and public service, UC Health looked forward to continuing to deliver on its mission in the years ahead.

4. **ADDRESSING COMMUNITY HEALTH NEEDS: COMMUNITY BENEFIT REPORT AND THE ROLE OF THE ANCHOR INSTITUTION**

[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 Rubin reiterated UC Health's pride in the release of its Report on Community Benefits for 2022–23. This report reflected the great variety of ways in which the academic medical centers are positioned to serve the communities and regions in which they are located. At the same time, UC was always looking for ways to strengthen that process and to extend its work beyond the walls of its medical centers. The Report on Community Benefits showcased that impact and benchmarked UC against other nonprofit organizations across the state.

Dr. Rubin presented the historical context of community benefit. Since the 1950s, in exchange for tax-exempt status, nonprofit hospitals are required to invest in the health and health care of the communities they serve. While UC technically does not need to report its community benefit like nonprofit hospitals because it is classified as a government entity, the University has opted to report on its community benefit as a matter of mission and because of the magnitude of the work that UC Health does. When community benefit was introduced in the 1950s it was originally focused on charity care as the gold standard, but in 1969 there was a broader recognition that charity care did not represent the entire investment in community benefit. In 2010, the Affordable Care Act added an additional process called the community health needs assessment which requires hospitals to develop a plan for addressing community health needs, a plan that ideally would be created by the

community itself and approved by the hospital boards. These measures were focused on nonprofit hospitals.

UC voluntarily tries to uphold these commitments and the same reporting standards in the provision of its community benefit report, which now involves UC Health population health teams, health equity leadership, and finance teams to ensure accurate reporting of all UC Health contributions. UC provides information in the form of reporting required by Internal Revenue Service (IRS) Form 990. Form 990 provides accountability in the reporting of nonprofits, allows for comparison and benchmarking across nonprofits, and sets the basis for evaluating improvement. Schedule H includes categories such as direct financial assistance, which was formerly "charity care" to individuals but now also includes the uncompensated portion of UC costs related to Medi-Cal contributions, community-engaged research, health professions training such as investments UC makes in its Programs in Medical Education (PRIME programs). Schedule H also has a category of "community health improvement," the only category that captures expenditures outside the hospital.

UC Health revenue was now well over $20 billion a year. Ten percent of this revenue was attributed to direct community benefit. This included a large category of uncompensated care for Medi-Cal, but there were also substantial investments in health professions education, research, community health improvement services, and subsidized health services. UC faculty practice groups contributed to uncompensated care in the outpatient setting as well as direct patient financial assistance. The Report on Community Benefits included information on the increase in uncompensated care for patients with Medicare.

Dr. Rubin compared UC's community benefit investment to the investments by over 200 nonprofit hospitals across the state. UC Health's contributions to direct community health improvement totaled 21 percent of contributions by all nonprofit hospitals in aggregate. UC Health contributed 40 percent of the aggregate in health professional education, 31 percent of research, and 26 percent of uncompensated Medi-Cal hospital care. UC Health has a significant footprint through investments in communities and its work with Federally Qualified Health Centers (FQHCs). He believed that, in spite of this collection of data, UC was likely underestimating the true magnitude of its community benefit impact.

UC Health investments in community benefit were not only the uncompensated medical care UC provides but included unique programs at each UC Health location. The intention of the U.S. Congress in the new community benefit provisions in the Affordable Care Act was that a hospital would strategically use its community benefit dollars to address the needs prioritized by the community. Like the nonprofit hospital community, UC Health was thinking about ways to better ensure that it is making direct investments that support the economic vitality and the health of communities around its hospitals. Most community benefit to date has been in the financial assistance and Medicaid differential categories, with comparatively little in direct community investment. This has been a topic of significant discussion and the motivation for UC Health to develop its anchor institution mission program, which recognizes the need to strengthen the process by which UC Health

connects community health needs assessments to actual strategies that improve the well-being of communities.

UC Davis Associate Vice Chancellor Hendry Ton explained that an anchor institution is a place-based, mission-driven organization like a hospital or university that leverages its economic power along with human and intellectual resources to improve the long-term health and social welfare of surrounding communities. The University of California was one of the largest academic systems in the country, employing more than 200,000 people across all divisions and generating $82 billion annually. UC supported nearly 500,000 jobs across the state. This economic powerhouse can be aligned with the goal of advancing equity and meeting the unique needs of underserved communities. Like universities and hospitals, anchor institutions set roots in communities and stay for the long term, which provides the foundation to tackle long-term, complex issues.

The anchor institution is part of an ecosystem of efforts by UC Health to advance health equity. The Diversity, Equity and Inclusion collaborative focuses on promoting these values among learners, staff, faculty and executive leaders in the UC Health professional schools. The Health Equity and Justice collaborative focuses on eliminating healthcare inequities by addressing systemic barriers to medical access and care and creating innovative clinical and social solutions that improve health outcomes. Community Benefits efforts aim to address community-identified health needs and support public health through community programs and high-quality care regardless of a person's ability to pay or insurance coverage.

The UC Anchor Institution Mission (UC AIM) collaborative is made up of the six UC academic health campuses working together to improve workforce development, procurement, and community investments with a focus on mitigating and addressing socioeconomic and health inequities. One might ask if UC Health, a healthcare system focused on providing excellent care and access to care, should be in the business of addressing poverty. Dr. Ton stressed that the answer to this question was an emphatic "yes." UC Health must consider upstream factors. Public health research has shown that only 20 percent of a person's overall health picture is determined by access to and quality of care; 30 percent is associated with behaviors, but 50 percent is associated with socioeconomic factors such as neighborhood safety, the physical environment, access to education, economic stability, access to digital technology, and the social and community context in all its forms. UC Health has an opportunity to address this 50 percent of overall health, and he believed that, in order to fulfill its mission, UC Health must consider these upstream factors, and this was the purpose of UC AIM.

UCSF Assistant Vice Chancellor Wylie Liu described the Community Health Needs Assessment (CHNA). Each UC medical center is required to conduct this assessment every three years. There are other nonprofit hospitals in the communities where UC medical centers are located, and they, and most local departments of public health, are required to carry out a CHNA to fulfill their public health accreditation requirements. Therefore, many of these entities have a practice of pooling resources to jointly conduct the assessment in their respective communities. The CHNA requires the collection of qualitative and

quantitative data. Qualitative data include discussions with the community about health needs and the barriers to health that they experience. This information is augmented by quantitative epidemiologic data often collected by local public health departments and other existing data sources. Communities are increasingly describing upstream social drivers of health as their priority. The questions and answers in these surveys and discussions have not changed much over a number of years, and UC Health must ask itself if it is adequately addressing community needs.

A review of the CHNA process at all six UC Health campuses revealed overlap and similarities. Communities across California have identified as priorities the need for economic security as well as security with respect to food and housing. These are not typical goals for institutions like UC Health. Many health systems across the country were having the same experience and finding that traditional community benefit activities have not met the needs articulated by communities. Through initiatives like UC AIM, institutions can learn from one another how to be more responsive to social drivers of health in communities, and this involves shifting and aligning everyday business norms, practices, and policies.

There are many strategies anchor institutions can adopt, and UC AIM has chosen to focus on three strategies: workforce development, procurement, and community investment in the form of low-interest loans. The short-term and intermediate goal was to improve economic opportunities, while in the long run the aspiration was to achieve health equity in under-resourced communities. This work is challenging and requires strong leadership, institutional support, and collaboration with partners.

The workforce development strategy involved partnering with community-based organizations such as workforce development nonprofits and local development offices as well as UC stakeholders such as Human Resources colleagues and hiring managers to provide workforce development programming and employment pipelines for populations who traditionally have not considered working in institutions like UC. In addition to hiring community members for entry-level positions, UC sought to develop these positions into higher-paying roles, and some locations have introduced community youth to job opportunities at UC. This effort could be boosted by taking a systemwide collaborative approach to setting goals and to a change in institutional culture, and by reinforcing best practices.

According to the last UC Health annual report, UC Health spent $1.7 billion on other supplies and purchased services including non-medical supplies, medical purchased services, repairs, and maintenance. There was a tremendous opportunity for UC to promote procurement with small, local, and diverse suppliers. UC Health should set targets like those for UC's non-health academic campuses. There were conflicting UC policies on procurement, and UC AIM would like to be involved in policy discussions to help identify solutions.

The third strategy, community investment, was probably the most challenging to implement. There were many definitions of community investment, and UC AIM has

adopted a definition of increasing the available lendable capital in under-resourced communities by making strategic social impact investments through low-interest loans to preserve small businesses, invest in social enterprise, and develop housing. UCSF was developing a pilot project for community investment, and Ms. Liu anticipated that UCSF would present a plan for Regents' approval in 2025. There was a need for systemwide guidelines for community investment opportunities that would align with UC AIM and UC's priorities for its communities. She concluded her remarks with two key questions: What are the boundaries for this work? What are the expectations for systemwide standards for policies and interventions?

Regent Makarechian asked about information on a slide shown earlier indicating an amount of $1.3 billion in Medi-Cal hospital uncompensated care. Dr. Rubin responded that this was the difference between the cost of providing care and the reimbursement UC receives from its Medi-Cal health plans.

Regent Makarechian asked how this amount was related to the $2 billion shown as net community benefits provided by the academic health centers. Dr. Rubin responded that the $2 billion was the amount of benefits provided by the hospitals; this total did not include benefits in the form of outpatient professional service fees. The risks related to Medicare have become profound over the last few years. For this reason, the report included an assessment of uncompensated costs related to the provision of services for Medicare-enrolled patients. UC Health estimated its total community benefit contributions as closer to $5 billion, but for the Report on Community Benefits and traditional reporting on IRS Form 990, it amounted to $2 billion.

In response to another question by Regent Makarechian, Dr. Rubin explained that the support for Medi-Cal was a relationship between the total revenue and the actual cost of care. There was usually about $1 billion to $1.5 billion in uncompensated Medi-Cal care. This care was paid for through a complex web of State-directed payments. Much work took place behind the scenes with the State and County health plans to optimize the financing of these services.

Regent Makarechian asked about the relationship between the cost of community benefit activities and UC Health's operating costs. Dr. Rubin responded that the $2.4 billion in uncompensated hospital Medicare patient care, indicated on a slide, would not traditionally be reported. Revenue was $27 billion, and community benefit contributions were estimated at just over $5 billion.

Regent Pérez referred to a statement by Dr. Rubin in the report according to which UC Health's total community benefit contribution amounted to nearly ten percent of UC Health operating costs and asked how this was calculated. Dr. Rubin responded that the IRS Form 990 was based on hospital income alone. The ten percent was a calculation based on $2 billion in net community benefits, not counting the $2.4 billion in uncompensated hospital Medicare patient care, in relation to $20 billion to $21 billion in costs. The UC medical centers were complex health systems, involved in research, education, and clinical

care. The perspective of the federal government and IRS Form 990 did not capture all the ways in which UC Health makes direct community contributions.

Regent Reilly praised the report for showing the significant amount of uncompensated care for and integration into the community by all UC Health locations. She asked about collaboration with other health systems when community needs are identified in San Francisco, Los Angeles, Irvine, or other locations to better and more effectively address needs in that community. Ms. Liu responded that UC Health was making such efforts. One challenge in this work was the need for a core or backbone to facilitate the work, and this was where efforts sometimes failed. There was no coordinator to bring the relevant parties together, and it was challenging to identify a priority that all parties can pursue. Efforts in San Diego had been more successful than in other places.

Regent Reilly suggested that UC Health could develop a pilot program, which could be devoted to a single priority every three years. UC San Diego Health Chief Executive Officer Patricia Maysent noted that UCSD Health's work with San Diego County on providing mental health services was one example of this work.

Student Observer Joselen Contreras emphasized the importance of healthcare equity. She had first-hand experience of how health inequities affect patients and communities. UC Health was California's second-largest provider of inpatient services to Medi-Cal enrollees. UC hospitals enjoyed high rankings, and the way that UC Health pushes boundaries to provide the best care was inspiring. She identified areas of concern in UC AIM efforts. The workforce development initiatives outlined in the report emphasized recruitment over retention, which might not fully address the issues plaguing the healthcare workforce, such as high levels of burnout. UC cannot solely focus on recruitment but must also keep the talent it has.

UC Health had a tremendous opportunity to foster workforce diversity by hiring from under-resourced communities but must consider the whole experience of these individuals and the barriers they face, such as transportation. Was UC providing enough support for under-resourced workers to get to work easily? To truly act as an anchor institution, UC Health must address the hiring process and the conditions that allow these individuals to thrive in their roles.

While UC Health's network extended through most urban centers, there was an urgent need to consider rural areas with limited healthcare access. The El Centro Regional Medical Center in the Imperial Valley was affiliated with UC San Diego Health. Despite this affiliation, the Imperial Valley remained a medical desert where residents faced significant challenges accessing healthcare services. Initiatives to support rural affiliates like the El Centro Regional Medical Center could address healthcare disparities by providing infrastructure investment, increased staffing support, and access to advanced technology. A dedicated effort to bridge these gaps in rural healthcare access would greatly benefit communities that rely on networks affiliated with UC Health. Ms. Contreras urged UC Health to deepen its commitment by supporting the workforce, under-resourced

employees, and rural health centers within UC networks. This would set a powerful example for healthcare systems everywhere.

5. **UCLA HEALTH MEDICARE ADVANTAGE PLAN UPDATE**

[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 Rubin began the discussion by noting that, across the UC system, the proportion of patients whose insurance was provided by government payers has continued to grow. In aggregate, three-quarters of UC patients were now covered by government payers. Older patients and those with disabilities who were enrolled in Medicare made up more than half of UC's government-insured patients. The fiscal challenges in managing their care were becoming even more acute than for Medi-Cal-enrolled patients in California. As increasing numbers of Medicare-enrolled patients turn to new Medicare Advantage plans, UC Health's experience with these new plans has not been good, either for patients or providers. This discussion would present a new approach to serving Medicare-enrolled patients. UCLA would create a new plan, the New Century Health Plan. By optimizing payer strategy, UCLA Health aimed to create a balanced approach that maximizes resources and aligns reimbursements with quality care goals. This approach would position UCLA Health as a leader in delivering equitable healthcare solutions tailored to meet the needs of Medicare beneficiaries and doing so sustainably into the future.

UCLA Health President Johnese Spisso provided background information on UCLA Health, which delivers comprehensive, patient-centered care through its clinically integrated health system. The system includes five hospitals owned and operated by UCLA, and one of them is a dedicated inpatient psychiatric hospital. The network also includes over 280 clinics throughout Los Angeles and Southern California providing primary care, secondary, specialty, and oncology services, with 600 primary care physicians and over 4,000 clinicians. UCLA was the first hospital in California to receive a Health Care Equity Certification from the Joint Commission, a recognition of UCLA's dedication to health equity and patient outcomes.

More than two years ago, based on its experience with Medicare Advantage plans, UCLA began planning to launch its own Medicare Advantage plan. Beginning in September 2022, UCLA collaborated closely with the Office of the President's legal counsel and with external consultants in this field to assess the structural and operational feasibility of launching a Medicare Advantage health plan that would meet all regulatory requirements and support UCLA's long-term strategic goals of taking care of more seniors in the community. UCLA Health received approval for the new plan via interim action in June 2023, and the New Century Health Plan was officially established in July 2023 as a California not-for-profit corporation wholly owned by the Regents. This entity is dedicated to offering a Medicare Advantage and prescription drug plan with a strong focus on enhancing healthcare access and quality for Medicare beneficiaries throughout Los Angeles County. UCLA was working closely with UC Health to ensure alignment with

systemwide goals and reinforcing its commitment to fiscal viability and its mission to provide equitable health care. Other UC campuses would be able to join the plan when they are interested and ready.

UCLA Health Chief Financial Officer Jonathon Arrington explained that UCLA established the New Century Health Plan as a Medicare Advantage health plan with the intent of having it fully licensed by the California Department of Managed Health Care as a provider of Medicare services in the Los Angeles County market as a starting point. UCLA has received a Knox-Keene license and has submitted a bid to the Centers for Medicare and Medicaid Services (CMS) to be a provider for a Medicare Advantage prescription drug plan for Los Angeles County starting January 1, 2025. The bid was accepted by CMS, and UCLA has executed its agreement to provide these services beginning on July 1 in Los Angeles County. UCLA was currently enrolling members and would fully launch the plan on January 1, 2025.

Traditional Medicare consists of three parts. Medicare Part A covers inpatient services for seniors who are Medicare-eligible. Medicare Part B covers physician services, including physician visits and laboratory and radiology services, among others. Members must pay a premium for Medicare Part B, about $175 per month this year. If seniors want prescription drug services, they must sign up for Medicare Part D, which provides the prescription drug benefits. These three parts do not cover other important benefits: vision, dental, and other supplemental benefits that are critical for wellness.

Medicare Advantage is a different package for seniors, providing coverage for Part A, Part B, and, if a health plan is licensed to provide prescription drug services, for Part D. UCLA's plan would cover supplemental benefits as well: vision, dental, hearing, and wellness services that create better outcomes for patients and ultimately reduce the cost of care. Medicare Advantage was a good opportunity for seniors versus traditional Medicare, and enrollment in Medicare Advantage was growing. Currently, 50 percent of Medicare beneficiaries were signing up for Medicare Advantage and 50 percent for traditional Medicare. The Congressional Budget Office projected that about 60 percent of all Medicare-eligible beneficiaries in the U.S. would sign up for Medicare Advantage by 2032. In Los Angeles County, about 60 percent or more of Medicare beneficiaries were already enrolled in Medicare Advantage plans, with 40 percent in traditional Medicare. There were approximately 1.7 million Medicare beneficiaries in Los Angeles County at this time, and this number would continue to grow.

Forty percent of UCLA patients were currently covered by Medicare, and this percentage would increase. UCLA needed to provide an appropriate vehicle for this constituency. Medicare Advantage plans are often chosen by members of diverse racial and ethnic groups, so the establishment of a Medicare Advantage plan addresses UCLA's mission of serving these communities and allows UCLA to pursue this in a financially sustainable way. The plan would help UCLA Health to grow in communities where it wishes to grow and to partner with medical groups in those communities.

Mr. Arrington recalled that the business case for launching this plan was based on growth in the Medicare Advantage market. Another important factor was the experience, over 30 years of delegated capitation management, that UCLA would bring to this undertaking. UCLA carried out due diligence, engaging a consulting group to provide an unbiased assessment of the market and UCLA's capabilities.

Over the years, in order to care for Medicare Advantage patients, UCLA has entered numerous contracts with other payers, and these contracts have generally not worked out well. Every two or three years, UCLA has found itself terminating a contract and signing a new one. Patients have remained loyal to UCLA, some going through three iterations of cancelled contracts in order to remain with UCLA Health. The New Century Health Plan would provide stability for these patients and not require them to change health plans every few years.

This was a provider-led health plan, unlike a traditional insurance company. UCLA had the perspective of a provider who knows patients' needs and a provider who contracts with health plans and understands the frustrations and challenges of health plans when one is trying to deliver good care to patients. UCLA was able to design its plan to meet the needs of its patients and knew how to partner with physicians and to make this a better process so that physicians want to partner with UCLA. UCLA Health believed that the plan was designed to deliver better outcomes for members and to advance UCLA's mission to provide high-quality health care to patients of all communities and income levels. UCLA engaged a firm to conduct a market or consumer survey. Seventy-five percent of all respondents expressed a preference for a provider-led and provider-owned Medicare Advantage health plan. About one-third or 33 percent of respondents listed UCLA Health in their top three choices of health plan owner and manager. These market data supported UCLA Health's view that this plan would provide an excellent opportunity for UCLA to serve its patient community.

Regent Makarechian asked about the financial sustainability of the plan and its cash flow analysis. Mr. Arrington responded that UCLA had an actuarial analysis carried out, including the risks of "adverse selection," i.e., members who join with serious medical conditions and, once their medical needs are addressed, leave and move to another health plan. UCLA also analyzed data from its own Medicare Advantage contracts and factored the adverse selection risk into its planning. Providers who have signed up for the plan have, for the most part, had to take on the full risk of adverse selection. For providers who cannot take on the full risk, UCLA has shared this risk for the most expensive services. The providers are the ones who can focus on preventative care and prevent a patient from being hospitalized. UCLA also had reinsurance to manage this risk.

Regent Pérez referred to the results of the market survey, the positive response rates of 75 percent and 33 percent, and suggested that this gave the impression of a volume of enrollment that might be necessary, but that this did not seem to be consistent with the plan's business model. He asked about the necessary threshold of participation for the model to work. Mr. Arrington responded that, in order to be sustainable in the long term, the plan would need about 15,000 to 16,000 covered lives.

Regent Makarechian requested more information on the basic requirements for the plan to be successful. Regent Pérez suggested that UCLA Health representatives discuss the financial model in more detail with Regent Makarechian.

Regent Batchlor expressed excitement about this health plan. She commended UCLA for taking risks and embarking on this program in a way that would continue to give patients access to care as they age into the Medicare program. Many hospitals were currently struggling with health plans and their practices, and many hospitals were dropping out of Medicare Advantage because of the bad behavior of these health plans. For UCLA, this was an opportunity for vertical integration while remaining in the Medicare Advantage program and providing a choice for patients. This was an excellent endeavor.

Regent Pérez noted that, in addition to helping transition UCLA patients as they age into Medicare, as mentioned by Regent Batchlor, this plan would also help expand the universe of potential UCLA patients both numerically and geographically. UCLA should help the Regents and others understand the degree to which UCLA had to establish a network of providers in different geographic areas in order to secure a Knox-Keene license. Mr. Arrington responded that Medicare requires that a health plan network meet "network adequacy." He presented a map showing CMS beneficiaries spread across Los Angeles County. Medicare requires that UCLA have a certain number of physicians, ancillary services, and access to hospitals within a certain distance of miles and time from all these beneficiaries. Another map showed the network locations that UCLA had built to cover the areas with Medicare beneficiaries. UCLA spent six to eight months extensively reviewing all physician practices in Los Angeles County for criteria of quality, experience with managing risk-based patients, and sharing UCLA's vision regarding access to patient care. Based on these criteria, UCLA has contracted with about 12 to 13 large independent physician associations.

Regent Pérez emphasized that this was perhaps one of the most impactful measures that the University could take to improve health equity in the most populous county in the state. The network that UCLA put together and the speed with which it was able to set up the network, consistent with UCLA values and quality, were impressive. Mr. Arrington noted that UCLA exceeded the CMS requirement for interpretation services and documents in the three most frequently preferred languages. UCLA secured the services of multilingual brokers for about 25 languages to reach the many communities in Los Angeles County.

Chancellor Hawgood asked about the pros and cons of each UC medical center replicating UCLA's work in its own market versus somehow leveraging UCLA's Knox-Keene license and infrastructure. Mr. Arrington responded that one approach would be for UCLA to add other markets to its existing license. UCLA would be able to expand within the UC family. Ms. Spisso recalled that UCLA had built up resources and spent almost two years in an intensive review of its organization and how it provides care at every level. UCLA could share these resources so that other UC Health locations do not have to replicate this work. Mr. Arrington noted that one could establish separate benefit plans for different markets. Samuel Skootsky, Chief Medical Officer of the UCLA Faculty Practice Group and Medical Group, commented that network adequacy for Medicare Advantage was a construct based

on the county. Larger counties with more complexity would present more challenges. Network adequacy might be easier to achieve in a smaller county, but it represented the main challenge.

Regent Pérez noted that UCLA had achieved this in the most complicated county.

Regent Sherman asked how much telehealth and mobile health, such as van services, factored into providing these services. Ms. Spisso responded that these services were an important factor. Eddy Ang, Chief Medical Officer for the Medicare Advantage plan, stated that UCLA was paying a great deal of attention to telehealth access. Network adequacy is important not just for primary care but also for access to specialists. UCLA was partnering with its independent physician associations in the community to ensure that patients have adequate and timely access to care, especially in areas where this may be a challenge. Telehealth was a major focus. Mr. Arrington added that, with respect to telehealth, CMS recognizes that some specialties are extremely difficult to provide in every location. CMS provides a ten percent credit toward network adequacy if a provider has telehealth services for a particular specialty. CMS recognizes telehealth as an important and necessary part of the portfolio.

6. **POSITIONING THE UC DAVIS SCHOOL OF VETERINARY MEDICINE TO RESPOND TO EMERGING CHALLENGES ACROSS CALIFORNIA**

[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 Rubin began the discussion by remarking that although the UC Davis School of Veterinary Medicine had not often been showcased at meetings of the Health Services Committee, its importance for the state and for public health has never been greater. At a time when emerging threats of new infectious diseases like highly pathogenic avian influenza are spreading among cattle and poultry in California and nationwide, California itself is falling behind in developing a veterinary workforce that is critical for monitoring such threats. The workforce shortage was now acute, and a bold strategy was needed to strengthen the veterinary workforce and the services it provides throughout the state to residents and industry partners.

Associate Vice President Deena Shin McRae recalled that there were 21 health professional schools in the University of California, including the top-ranked veterinary medicine school in the nation. The UC Davis School of Veterinary Medicine (School) not only provides care to pets, animals in shelters, livestock, and poultry, but the School's trainees, faculty, and graduates lead groundbreaking research and protect the public through the prevention and management of diseases such as H5N1. She introduced the School's Dean, Mark Stetter, who previously served as Dean at the Colorado State University and whose research interests included advancing minimally invasive surgery in non-domestic species.

Dr. Stetter noted that the School at UC Davis was one of only two schools of veterinary medicine in the state; the other one was a smaller private school in Pomona. The School

was based on the Davis campus but had facilities and programs throughout the state. In the following year, the School would open a veterinary genetics laboratory in Sacramento at the Aggie Square complex. There was a dairy facility in Tulare, an equine facility in Templeton, a specialty hospital for small animals in in San Diego, and other facilities in Turlock and San Bernardino. Many of these were part of the California Animal Health and Food Safety System, a partnership with the California Department of Food and Agriculture.

The School used the term "One Health" to refer to the intersection of animal health, human health, and the environment. The One Health Institute at UC Davis represented this multidisciplinary approach. Dr. Stetter drew attention to two programs in the Institute: the Oiled Wildlife Care Network, which responds to oil spills and animals harmed by them, and the California Veterinary Emergency Response Team, which was designated by the State in the last two years due to more frequent wildfires and natural disasters and which assists with animal evacuations and care.

The veterinary workforce shortage was a major challenge in California and the nation. Dr. Stetter presented a chart showing numbers of veterinary medicine graduates in the ten states that produce the fewest graduates per capita, and California was the state with the fewest graduates. He presented a map showing veterinary care disparity by California counties. In many parts of the state, it can take hours to drive to find appropriate veterinary care.

Veterinarians have an important responsibility in maintaining the safety of the food supply and in monitoring zoonotic diseases. Dr. Stetter presented a map showing U.S. states with poultry cases of avian influenza, which had been occurring for about two years. The virus has moved from birds to mammals, and another map showed states with dairy cases of H5N1 in the last six months. The disease was now affecting people as well. More than 50 percent of epidemics and pandemics are caused by diseases moving from animals to humans. The One Health Institute has for decades studied how this kind of transmission happens and works to predict and minimize future pandemics.

Dr. Stetter summarized some of the effects of avian flu in California. More than nine million birds have had to be euthanized. This has had an effect on egg prices. Two weeks prior, 133 dairies in California were affected by avian flu, but as of this day, more than 300 were affected. One was only now beginning to understand the economic impact on the dairy industry. A few weeks prior, there had been 13 cases of avian flu in humans in California, but now there were over 30 cases. New cases had occurred in the last few days in the State of Washington.

The School's pro bono work included free veterinary care for immigrant workers and people experiencing homelessness. As the veterinary workforce crisis continued, these programs would be at greater risk.

Overcrowded animal shelters were another area of risk. Prior to the COVID-19 pandemic, there was a significant decrease in animals being euthanized in shelters across the country. In California, the number was close to zero. Since 2020, instances of euthanasia in animal

shelters have been increasing, and this was because shelters were not able to hire veterinarians due to the workforce shortage.

The School makes significant contributions in research, discovery, and translational medicine. Dr. Stetter presented a video about groundbreaking research at UC Davis that was able to help both animals and people with spina bifida. Spina bifida is a disorder where the spine does not fully form, and a child or an animal is born with the inability to walk. In July 2018, UC Davis launched a clinical trial combining surgical and stem cell interventions in dogs with spina bifida. This helped lead the way to the first-ever trial in humans. The spina bifida project used whole cells to treat both dogs and people. In spring 2021, UC Davis launched the CuRe clinical trial, the first spina bifida treatment for humans combining fetal surgery with stem cells. In November 2023, the CuRe study received an additional $15 million to advance to the next stage. A boy named Tobi, diagnosed with spina bifida, received this treatment and was born able to walk. A dog named Arthur, born with spina bifida, received stem cell transplant surgery and was able to walk. UC Davis fosters team science and offers opportunities for this kind of research that few other institutions can offer.

Dr. Stetter commented that no one would allow a procedure that had never been performed before to be performed on their child, and the U.S. Food and Drug Administration (FDA) would not immediately approve a new procedure, but being able to prove that a procedure works for animals with the same disease can lead to FDA approval for new therapies.

When the veterinary teaching hospital opened at UC Davis in 1969, it saw about 3,000 to 4,000 patients a year, including dogs, cats, horses, cows, pigs, sheep, birds, and snakes. The hospital was now treating about 50,000 patients a year and could not treat any more than this number. Many patients were turned away. The School had about 600 students in a four-year program, with 150 students per class. Five years ago, there were about 1,000 applicants to the School per year. Three years ago, that number increased to over 2,000, and this year over 3,000 students would apply to join a class of 150. There were thousands of qualified students and a huge need for veterinarians. Patient need in the UC Davis region probably amounted to more than 70,000 patients annually, and the School would like to be able to accommodate 800 students.

In thinking about the future, the School envisioned a decade of transformational growth that would allow it to better serve the State of California, educate more veterinarians, and promote discoveries that can help both animals and people. Dr. Stetter presented an example of a recent graduate, Dr. Adrian Santoyo Saldaña, a first-generation student who came from the Central Valley and would return to work in the Central Valley. The School was not able to increase class size because of limitations in classroom space and facilities, but it can think differently about admissions and how it is serving the state. This year, 58 percent of the School's incoming class would be first-generation students, almost double the number of first-generation students in prior years, and 34 percent would be Hispanic/Latino(a). The School was diversifying its class.

Veterinarians, like their human health colleagues, have a large number of specialties. UC Davis was the single largest educator of veterinary specialists, with about 40 different specialties including equine surgery and ophthalmology. The School would like to increase its specialty training as well as its caseload and facilities.

The School engaged a design consultant to review the existing facilities and discussed its growth goals with the consultant, who produced early-stage concepts. The School envisioned a new education building, a new small animal hospital which would be used for specialty training, a new primary care hospital, and a large animal hospital facility. This was part of the School's ten-year plan to accommodate the needs of the state.

Regent Leib referred to the tremendous need for veterinarians in the state and asked about the possibility of expanding veterinary medical education to other UC locations such as Irvine and San Diego. Dr. Stetter responded that the largest investment in starting a new veterinary school is a teaching hospital, which must be able to accommodate animals of all shapes and sizes and all specialties. Campuses considering establishing a new education program might start with a two-year program at their campus for much of the classroom learning. If the campus has a medical school or strong biomedical sciences program, there might be faculty in place, and this would reduce the amount that the campus needs to hire and build. This would be followed by two years of study at a location like UC Davis with a teaching hospital. A campus might use a "two plus two" plan like this rather than investing perhaps $1 billion in a new veterinary school.

Regent Leib asked how UC Davis could accommodate students from other campuses. Dr. Stetter responded that the School could not accommodate these students in its current situation; it would need to expand its facilities, a project with a significant cost.

Regent Beharry asked if the School had considered developing programs at UC San Diego or UC Merced. Dr. Stetter responded that the School was putting forward a proposal related to the Programs in Medical Education (PRIME), the DVM Serve Program. The program would allow the School to recruit students from the 15 most underserved counties, many of them in the Central Valley.

Regent Beharry congratulated the School on the fact that student debt upon graduation had decreased since 2018. It was currently approximately $98,000, and he asked how the School was working to further reduce this debt. He also asked about compensation for residents, interns, and fellows and how this was related to lowering the debt. Raising these salaries would set a higher standard for the profession. Dr. Stetter responded that the average debt of students has decreased due to financial aid and scholarships, now over $8 million a year. While there was a workforce crisis, this meant that there was greater demand for the School's graduates, and they were being hired at higher salaries in the last few years than they were ten years ago. In 2018, salaries were lower than the average debt, but this was now reversed. Graduates had less than $100,000 in debt, and starting salaries might be $150,000 to $160,000 for new graduates. This was a positive trend. In the private sector, graduates were offered hiring bonuses, relocation packages, and other debt relief packages. Dr. Stetter acknowledged that there were salary gaps depending on region and

specialty. Small animal medicine offered significantly larger starting salaries than veterinary work in the Central Valley or with livestock; salaries for veterinarians in the latter category had not increased as much as they should. There were significant gaps.

The meeting adjourned at 3:40 p.m.

Attest:

Secretary and Chief of Staff