The Regents of the University of California

HEALTH SERVICES COMMITTEE
April 10, 2024

The Health Services Committee met on the above date at Carnesale Commons, Los Angeles campus and by teleconference at 1130 K Street, Sacramento and 450 East Harbor Boulevard, Ventura.

Members present: Regents Makarechian, Park, Pérez, Reilly, and Sures; Ex officio member Leib; Executive Vice President Rubin; Chancellor Hawgood; Advisory members Marks and Ramamoorthy

In attendance: Regent Batchlor, Faculty Representatives Cheung and Steintrager, Staff Advisors Emiru and Mackness, Secretary and Chief of Staff Lyall, Interim Deputy General Counsel Sze, Chancellors May, Muñoz, Wilcox, and Yang, and Recording Secretary Johns

The meeting convened at 12:40 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 January 24 and February 14, 2024 were approved, Regents Leib, Makarechian, Park, Pérez, Reilly, and Sures voting "aye."[1]

2. **UPDATE FROM THE EXECUTIVE VICE PRESIDENT OF UC HEALTH: ACADEMIC MEDICINE AT THE CROSSROADS OF MISSION AND MARKET FORCES**

[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 underscoring the challenges confronting UC medical centers and schools as they advance their teaching, research, and public service mission. The changing healthcare landscape and critical risks to academic health systems nationwide were being experienced in California as well. UC Health programs had positioned themselves well to confront these challenges but felt the strain of a healthcare market that required them to grow to ensure that they continue to thrive into the future. This item would focus on the threats facing academic medical centers. Understanding these dynamics would prepare the Regents for the challenges ahead and clarify the need for the expansion of UC medical centers.

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

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Advisory member Marks, Vice President for Health Affairs at the University of Colorado, then gave a presentation on the current state of academic medicine as it strives to fulfill its mission and is subject to market forces. She observed that medical schools provide four critical elements for the public good. They are the primary educators of the U.S. physician workforce; they are epicenters for medical research, discovery, and innovation; their leading-edge clinical programs treat uninsured and insured patients; and their community service and benefit programs enhance the health and well-being of communities. As essential as these four missions are to the health of the nation, medical school budgets have been forced to become an intricate tapestry of subsidies and cross subsidies in the absence of adequate public and private sector support.

Ms. Marks presented a chart showing funding sources for U.S. medical schools, with funding profiles for public schools, private schools, and UC Health. All medical schools are required to submit an annual financial report as a factor of accreditation, and 65 percent of medical schools are public institutions. The three funding profiles on the chart were similar, with only a few notable differences. On average, public medical schools received about eight percent of their budget from State higher education funding, but State support made up only four percent of the combined budget of the UC medical schools. Another notable difference was in UC Health research support. Research grants comprised almost one-third of UC medical schools' budget, a higher percentage than for public and private schools. UC medical schools generated $3.6 billion in research support annually, about half of which was National Institutes of Health (NIH) funding.

The economics of public medical schools were different from the economics of their parent universities. U.S. medical schools were established for the primary purpose of educating physicians, but over the last several decades, medical schools have leveraged educational mission support and faculty talent and expertise to build major research and clinical enterprises that now dwarfed the educational mission. The research and clinical missions together now represented 80 percent to 90 percent of medical school budgets; at UC this figure was 87 percent. Programs supported by this part of the budget relied on soft dollars leveraged from external revenue sources that were at risk every year. The generation of these funds was heavily dependent on the talent, productivity, and competitiveness of faculty. Most school of medicine faculty in the U.S. were expected to generate a major portion of their own salary support from these external sources. This was a very different faculty compensation model than in most universities.

Ms. Marks then presented a chart showing the same budget data over 45 years, from 1977 to 2022. The chart illustrated the prodigious growth of medical schools and the enormous change in the composition of their financing. In the late 1970s and 1980s, the various revenue categories were roughly equal in size, but this had changed significantly over the past few decades. Schools of medicine had become major economic engines in universities and communities.

Tuition revenue and State support together were the primary source of funds supporting the educational mission of medical schools. The chart showed that educational support had remained relatively flat over time in spite of increasing enrollments and the establishment

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of new medical schools. This meant that per capita State and institutional support for medical schools had significantly declined while the cost of delivering educational programs had increased, as had the demand for institutional student aid. A large and growing number of medical school educational programs were now in deficit. Schools must look to other revenue sources to subsidize their educational programs and support faculty salaries. Unlike the rest of the University, the medical schools were much less able to use tuition and enrollment to offset budget deficits.

Ms. Marks emphasized the central importance of the research mission for the success of the medical schools, the hospital systems, and the University as a whole. The impact of research was greater than dollar numbers alone would indicate. Research rankings were still the essential criterion for a medical school's reputation and stature and its ability to attract outstanding faculty and students. This reputation extended to the hospitals and their ability to attract patients and nationally recognized clinical talent. The fusion of the academic mission with clinical programs differentiated academic health systems from competing hospital systems. It was no coincidence that most of the nation's top-ranked hospitals were university teaching hospitals partnered with top tier research-intensive medical schools. Ms. Marks declared that this correlation between research and clinical excellence and rankings was nowhere more evident than at the University of California.

A significant institutional investment was needed to develop and sustain a viable research program. Studies by individual medical schools and the Association of American Medical Colleges estimated that necessary institutional cross subsidies accounted for 50 percent of total direct costs. For most medical schools, clinical revenues have become the major source of that subsidy and investment. Any school that wishes to build and maintain a viable research enterprise must have the will and ability to generate these funds to cross subsidize research. A critical question for many institutions was whether the culture of the school and its partner hospital were strong enough to survive a downturn in profit margins.

Ms. Marks presented another chart showing a breakdown by category of research costs and investments subsidized primarily by medical school and institutional funds. While indirect cost recovery and endowments were important in supporting programs, they were not able to cover most research expenses and could not eliminate the educational mission deficits. Clinical funds have become the primary source for underwriting the academic mission. These clinical funds that are transferred and support academic programs come mostly from two sources: revenues generated by faculty physicians' clinical work and revenues generated by partner hospitals.

The largest component of the medical schools' budget was their clinical mission and revenue. The largest category of income was physician professional fee reimbursement for clinical care provided by faculty. This was distinct from hospital facility, technical, or ancillary fees, which were part of the hospital budget, and distinct from program transfers. It had long been the largest, fastest growing, and most flexible revenue source in a medical school's budget and now accounted for 60 percent to 70 percent of medical school budgets. It was the major source of subsidy for research and education programs as well as community service efforts.

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The need to subsidize academic programs and deficits was continuing to grow, and this increased pressure on hospitals' and physicians' clinical margins. Most challenging of all were the issues facing the clinical enterprise, which created tension in medical schools and sometimes between medical schools and their partner hospitals, and tremendous pressure on faculty.

Nationally, both physician groups and hospitals were experiencing continuing declines in reimbursement rates from Medicaid and Medicare as well as from commercial payers. Medical centers were no longer enjoying the healthy profit margins of years past. Margins from commercial contracts were cross subsidizing the reimbursement gap from government payers. The decreasing margins had significant implications for the continued ability to subsidize the core mission and contribution to the public good.

Dramatic changes were taking place in healthcare delivery and reimbursement. Certain market and reimbursement factors were not often identified or discussed but had a direct and indirect impact on academic health systems. One such factor was the commoditization of healthcare services, which was reducing margins. Commodities are products and services that trade only on price, are treated as interchangeable parts, and are stripped of any differentiating characteristics. This approach was being applied to a growing number of healthcare services and providers. Insurers, employers, and even patients were comparing prices and to an increasing degree were looking for the lowest cost, with the assumption that the quality was the same or good enough. Many manifestations of the market had elements of commodity pricing but were not typically recognized as such. Narrow networks were an example of this. Insurance companies were marketing health plans which offered a very limited number of hospital and physician providers considered in network. These were often providers willing to take discounted rates and increased utilization controls. These networks may even include physician groups owned or employed by the insurance companies themselves. Increasingly, and across the U.S., insurers were trying to exclude university providers and programs from these networks, if possible. This was due to these providers' higher prices and more complex services and therapies. Out-of-network patients who seek advanced therapies from university providers must pay out of pocket for this care, if university providers are excluded from these networks.

Another factor was the ongoing consolidation of the U.S. healthcare industry, and in Ms. Marks' view, this was the most significant impact and market trend. All entities were trying to grow larger and leverage market strength. Currently, five major insurance companies controlled a huge swath of the commercial market, which gave them significant market leverage and power. In some cities, only one or two insurers dominated the market and exerted massive, monopolistic control on premium prices. Everyone was familiar with monopoly, but Ms. Marks drew attention to monopsony, a market condition when markets have a single or dominant buyer, and the buyer has so much purchasing power that it can disrupt the normal prerogative of the seller to set its prices. The consolidation of the insurance market had allowed the big health insurance companies to become both the dominant seller and the dominant buyer, giving them the power to increase their premium prices and profits while forcing down the prices and margins of academic health systems.

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While the academic health systems might be the seller, the insurance companies would determine the price. Monopsony had been one of the invisible forces behind the consolidation of hospitals, as hospitals sought to ensure that they do not become marginalized. If a hospital is not a major hospital system with market dominance, it might not have enough leverage to negotiate reasonable reimbursement rates or avoid being carved out of network. This dynamic had created a special challenge for university and children’s hospitals. These hospitals had historically had a strategy of remaining neutral, independent hospitals, not exclusively or legally aligned with other systems, relying on the entire market for referral of patients to their tertiary and quaternary programs. This strategy no longer functioned as hospital systems were consolidating. Over the last ten to 15 years, a growing number of major academic health centers were developing their own health systems or partnering with community hospitals, for-profit hospitals, faith-based hospitals, and even private equity groups. A major motivation for this strategy was to gain more leverage and avoid marginalization. For academic health systems, consolidation was motivated by more than just financial considerations. Having a larger footprint was critical to maintaining and expanding access for patients, securing training sites for students and residents, and enhancing the ability to provide critical services and unique programs to the community. This strategy pursued economies and efficiencies of scale, but also maintained expertise at scale, which was essential for being able to offer true centers of excellence. Due to these dynamics, academic institutions across the U.S. were pursuing initiatives similar to the recent hospital affiliations, acquisitions, and expansions undertaken by UC Health campuses.

Another concern was that the erosion of the academic mission and lack of support for this mission may lead to an exodus of faculty. Clinical faculty salaries often lagged the market by 15 percent to 20 percent or more. Academic health centers had been able to retain their extraordinary faculty because many faculty were willing to take salary discounts necessary to subsidize the academic mission in return for the opportunity to be engaged in the academic mission. The unrelenting demand for clinical productivity and revenue was now limiting opportunities for clinicians to participate in the mission in ways that provide faculty satisfaction and value in lieu of compensation. As faculty positions become indistinguishable from non-academic clinical practice, a growing number of talented faculty become less willing to accept an academic salary cut. If clinical work is all they do, they realize that it would be better to go into private practice or hospital employment.

All these challenges have necessitated existential decisions by academic medical center leadership. Ms. Marks stressed that there was no existential risk for UC Health, but UC was facing the same environmental challenges as other academic health systems, which were responding to the challenges by pursuing transformational strategies to grow their systems. Some institutions were also changing their internal organizational structure and cash flow model. The magnitude of all these changes and the associated mission-critical decisions were not without risk, and not only financial risk. For some institutions, there would be an existential risk to their mission. An Association of American Medical Colleges study of expansions and restructuring strategies at academic medical centers confirmed that many initiatives were financially and competitively successful, but the study also identified unintended consequences and risks, ranging from the potential loss or dilution

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of governance controls to a significant re-ordering of the internal system relationships. The study found that institutions were very adept at providing comprehensive due diligence on financial and operational aspects of clinical strategy but often failed to perform equal due diligence on how these initiatives might affect the rest of the school and mission. This had led to a number of difficult consequences. Some system expansions or restructuring initiatives ended up shifting the institution's center of gravity and the locus of power, control, and decision-making away from the university, medical school, and faculty and toward the health system. At some institutions, this shift eroded the relationship between hospital, school, and faculty. At other institutions, this presented a challenge regarding prioritization of the mission, questions of who was setting priorities and funding for priorities. Academic health systems must respond to market imperatives. They must identify fundamental mission issues, principles, and terms and reflect on how to incorporate the protection of the core academic mission and principles into the basic architecture of strategies, contracts, and affiliation agreements in order to ensure that the integration of the clinical enterprise did not lead to the disintegration of the academic enterprise.

Regent Sures asked if UC Health would have to make a significant shift in strategy in order to fund its operations. Dr. Rubin responded that the integration of the medical schools and medical centers was much stronger at UC Health than in other institutions. UC's geographic spread across the state was an antidote to challenges for patient access. Investments in the health of students, faculty and staff must be accompanied by a multi-point strategy on self-funded health plans, working with the State on Medi-Cal priorities, payer contracts, and revenue cycle. He anticipated that UC Health would be the originator of health plans that would prevent what he saw as relationships that were distracting and harmful to the conduct of UC Health's work.

Regent Sures supposed that the issue of monopoly would continue to be significant, given the size of UC Health, the number of patients it serves, its access across the state. He asked if UC should be taking a harder stance against some insurance companies. Ms. Marks responded that she believed that UC Health should do so, but must consider whether it has sufficient power, leverage, and scale. In her view, this was the factor that had driven hospitals to consolidate; to protect their negotiating position in a consolidated insurance market. There was an assumption that Medi-Cal care would be funded by healthy profit margins from commercially insured patients. Every year, when contracts were renewed, these margins were becoming smaller. Health systems must differentiate their services so that these are not commoditized.

Advisory member Ramamoorthy related that, in her more than 20 years at UC, she had observed a growing tension between the clinical and academic missions. In the current landscape, financial pressures often prioritized clinical productivity and revenue generation, overshadowing the other critical missions. Dr. Ramamoorthy believed that this had led to "mission drift," diverting attention from academic priorities for faculty. The effort to achieve a balance among clinical, teaching, and research responsibilities had stretched faculty members thin and reduced their availability for crucial activities like mentorship, curriculum development, and clinical discovery. The overall dependence on

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clinical revenue presented significant hurdles to the academic mission and to healthcare institutions like UC Health and had led to attrition in academic medical centers. Faculty join academic medical centers to participate in the core mission, and when this mission drifts, there is a realization of the surcharge for working in academic medical centers. Dr. Ramamoorthy noted that one of her mentees was considering a job for a non-academic competitor of UC which could offer her 50 percent protected research time, more than any academic health system in California could offer. UC Health was competing with non-academic health systems not only for clinical work but increasingly also in the research arena. To address these challenges, UC must strive for equilibrium between clinical revenue generation and the pursuit of academic excellence. This would require a strategic allocation of resources in a comprehensive and sustainable manner. UC Health should aim to cultivate an environment in which academic faculty can thrive and transmit their passion for research and education. Dr. Ramamoorthy expressed confidence in UC Health's ability to address these challenges, but this would require a focused effort.

UCLA Health Sciences Vice Chancellor John Mazziotta commented that UC medical centers and health systems would continue to grow for the reasons mentioned in this discussion. The growth in the number of providers would not all be growth in faculty. The UCLA School of Medicine now had 4,700 faculty. It would make sense to have core faculty focused on teaching and research and staff physicians and other providers whose focus would be clinical care. He anticipated that UC Health locations would soon come to a point at which they would have to make a decision about the size of faculty and the nature of other positions they would recruit. Some providers might wish to work in the UC environment without having a teaching role, and UC had not thought in these terms in the past.

Committee Chair Pérez noted that there had been barriers of institutional culture preventing the course that Dr. Mazziotta had just suggested. He asked if there were also structural barriers, such as policies, which prevented medical centers from exploring this path. Dr. Mazziotta responded that there were some policy barriers, such as questions of benefits and salary caps. This could be discussed at a future meeting.

UC San Diego Health Sciences Vice Chancellor John Carethers expressed agreement with Dr. Mazziotta. UC Health was in competition with private entities which did not share UC Health's multiple missions. Clinical faculty must be paid competitive salaries. Fifty years earlier, in academic health systems with a fee-for-service model, the work of one clinician might support ten academic faculty members. This was no longer the case. For UCSD Health to compete in its local environment, to address market pressures, and to maintain its core mission, restructuring would be necessary.

Ms. Marks observed that, as academic medical centers grew, their faculty would no longer be able to serve the broader enterprise. New relationships and networks of physicians would need to be created. This raised issues of differences in employment, compensation, and benefits categories as well as institutional reputation.

Dr. Carethers remarked that challenging situations arise when academic physicians and full-time clinicians work side by side at the same site and are paid at different rates. This was a structural and cultural issue.

Chancellor Wilcox noted that this topic was being discussed by universities across the U.S., and not just at medical schools. One important question concerned how much instruction is offered by adjunct faculty members and by professors. UC needed to determine its long-term position on this matter.

Faculty Representative Cheung commented that, as UC Health was growing, the job description of academic physicians had changed. UC Health must have a clear vision of how it wishes to increase its service providers. He expressed agreement with Dr. Mazziotta on a distinction between core faculty and clinical providers.

Chancellor Hawgood referred to the issue of monopoly and monopsony of insurance companies, and the fact that a few academic health systems were entering the insurance business. The University of Pittsburgh Medical Center (UPMC) Health Plan was one example of this. He asked about the size and scale an academic health system would need in order to be successful in providing insurance. Ms. Marks responded that she believed that there was an opportunity in this area. Academic health systems were competing in a for-profit insurance market. Insurance companies had profits built into their costs and had developed an administrative infrastructure not focused on paying claims but specifically designed not to pay claims, an administrative bureaucracy to delay or deny payment. There was room for academic health systems to provide a better product, but one had to have the appropriate infrastructure and reserves in place. She believed that there was also an opportunity for academic health systems across the U.S. to combine. An important factor in the insurance market was the ability to provide coverage for large employers that might be located in other communities or states.

Regent Park referred to a recent article in the *New York Times*, "Insurers Reap Hidden Fees by Slashing Payments. You May Get the Bill." This article revealed practices that she found appalling. She believed that UC Health and health care could not thrive in the current insurance market.

Regent Raznick asked about the factors involved in government support for public medical schools. Ms. Marks responded that this segment of the budget included higher education funding from the State as well as indirect cost recovery paid to institutions. Institutions varied in how much of the indirect cost recovery they passed on to their medical schools.

UC Riverside School of Medicine Dean Deborah Deas emphasized that, as UC Health considers options to address the challenges mentioned in this discussion, it must also be mindful of its institutional culture. It would be problematic to create a culture with different classes of physicians where an academic physician who carries out research is paid substantially less than a clinician. Academic faculty drive the prominence and elevate the rankings of the UC Health clinical enterprise and make UC hospitals the hospitals of choice

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for patients. As in the situation of the mentee described by Dr. Ramamoorthy, UC faculty might be lured away by non-academic health institutions.

UCSF School of Medicine Dean Talmadge King stressed the uniqueness of the UC system and UC Health. The UCSF annual budget was three times the annual budget of the average public medical school. This was due to the research-intensive nature of the institution. UC must find a way to protect its research function. Because UCSF was research-intensive and funding to pay faculty came from multiple sources, UCSF was not able to pay providers as much as other medical schools. UCSF's providers were dedicated to the mission of UCSF and were willing to accept lower compensation, but Dr. King noted that this willingness extended only to a certain point. As mentioned earlier, differences in compensation levels would cause problems. UC Health should be careful in pursuing an expansion of faculty, a process that could be fraught with many difficulties.

Regent Reilly asked what advantage UC Health had in this landscape, and which top three factors UC should be mindful of, which might include unintended consequences of expansion. Ms. Marks responded that the success of UC's medical centers and medical schools was directly related to the prominence of UC Health's research enterprise. Paying for this research enterprise was a challenge and required many institutional cross subsidies, in part simply to pay for protected research time. Academic health systems had built much on the back of the clinical enterprise, with the assumption that margins would continue to increase. However, although revenues were increasing, margins were decreasing. Another challenge was found in the demographics of the U.S. and the aging of the population, which would lead to a reckoning on Medicare. When Medicare was established in 1964, it was predicated on four employed people supporting one beneficiary; the ratio currently was about two to one. Ms. Marks anticipated that there would be downward pressure on Medicare reimbursement. The large percentage of Medi-Cal patients in UC Health's payer mix represented a challenge that was intertwined with political and public policy issues. There were no easy solutions. Academic health systems must do a better job of articulating the public good that they provide and of advocating for this public good. In increasing faculty and the workforce, one must find a critical balance between "academic socialism" and capitalism. Many of the most valued faculty believe in a degree of "academic socialism" in that they are willing to give up some compensation to fund and support the public good that academic health systems provide. But if 85 percent to 90 percent of the system's budget is dependent on faculty productivity, a healthy dose of capitalism is needed. It was a question of mixing socialist and capitalist economic models within a medical school, while adding faculty physician groups who function on the "capitalist" side of the enterprise. Academic health systems must take a careful, sophisticated approach in seeking solutions to these complex problems.

3. **APPROVAL OF MARKET-BASED SALARY ADJUSTMENT FOR PRESIDENT – UCSF HEALTH CARE NETWORK/CHIEF MARKET DEVELOPMENT OFFICER AND SENIOR VICE PRESIDENT, UCSF HEALTH, SAN FRANCISCO CAMPUS AS DISCUSSED IN CLOSED SESSION**

Committee Chair Pérez explained that this item had been removed from the agenda.

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4. **OVERVIEW OF DELEGATED AUTHORITY FOR TRANSACTIONS IN THE HEALTH SERVICES COMMITTEE CHARTER AND AUTHORITY TO APPROVE INTERIM ACTIONS**

Committee Chair Pérez explained that this item had been removed from the agenda.

5. **UC HEALTH'S ROLE AS AN ESSENTIAL MEDI-CAL PROVIDER**

[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 this discussion about UC Health's growing work on behalf of Medi-Cal patients. He recalled that the Medi-Cal program is a State-administered program that relies heavily on Medi-Cal-managed health plans to partner with healthcare providers to manage and reimburse for care provided to Medi-Cal-enrolled patients. While California should be proud of the extensive coverage it provides to low-income residents through Medi-Cal, these residents could not always find the care they need in a timely manner. There was not sufficient capacity among available providers and facilities across the state, and this resulted in a lack of access for commercial, Medicare, and Medi-Cal patients alike. Although UC facilities accounted for less than six percent of hospital beds in California, UC Health was the second-largest provider in the state of hospital services to Medi-Cal enrollees. Patients were traveling ever-longer distances to seek care at UC Health locations, and UC Health campuses were expanding their networks further into communities that were farther away from the academic medical centers. Dr. Rubin estimated that, through acquisitions this year alone, UC Health would increase its volume of Medi-Cal patients by 40 percent. UC Health programs were running Federally Qualified Health Centers (FQHCs) or partnering with FQHCs throughout the state. In order to accomplish this work, UC Health must resolve critical reimbursement challenges.

UC Health Associate Vice President for Health Policy and Regulatory Affairs Tam Ma noted that Medi-Cal now provided coverage for one-third of Californians, or 15.5 million people. Over the past dozen years, California had invested in coverage expansion by implementing the Affordable Care Act and using State funds to cover undocumented patients who are eligible based on income. These efforts had been a critical factor in reducing the percentage of uninsured patients, which was now at eight percent, compared to over 20 percent before the Affordable Care Act. Over 90 percent of Medi-Cal patients were enrolled in managed healthcare plans which are responsible for arranging their care and ensuring that there are adequate networks of providers. Currently, UC's academic medical centers had contracted with almost every Medi-Cal-managed healthcare plan in California. Ms. Ma noted that these plans have control over where patients receive care, so that even if patients desire to come to a UC hospital, they might not be directed to one. UC Health was an essential safety net provider. UC hospitals were designated public hospitals, along with county hospitals. Three UC Health campuses operated former county hospitals—UC Davis, UC Irvine, and UC San Diego. A high concentration of UC care was provided in metropolitan areas near the UC hospitals, but UC Health had significant geographic reach in rural areas.

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Ms. Ma presented a chart illustrating the growth in UC inpatient and outpatient hospital services provided to Medi-Cal patients from 2013 to 2022, including significant increases in inpatient days and discharges, and outpatient visits. UC had also increased access to ambulatory services in primary and specialty care in a variety of settings. In 2023 alone, UC Health had more than one million ambulatory visits. Another chart showed UC Health's systemwide payer mix. Medi-Cal patients represented a large percentage of inpatient days and emergency department services, but only about 15.5 percent of ambulatory and specialty care.

UC care provided to Medi-Cal patients included behavioral health. UC was unique in that it was adding inpatient capacity as other health systems were reducing numbers of beds. The UCLA Mid-Wilshire behavioral health campus would increase inpatient psychiatric beds by 61 percent. All UC Health campuses had contracts with counties to provide behavioral health services, program evaluation, training, and implementation support.

In the population health realm, UC was undertaking work to improve access to chronic disease management in vulnerable communities, with a focus on diabetes and hypertension care. UC provided screening for social determinants of health and referrals to services. UC Health campuses had street medicine programs to provide care to unhoused individuals. UC Davis and UCSF provided care to patients in rural parts of Northern California. UC San Diego provided management and leadership at El Centro Regional Medical Center in Imperial County.

All UC Health campuses had prenatal and perinatal health programs to address disparities in maternal health outcomes. UC provided high-risk pregnancy care. This was important because other hospitals were reducing labor and delivery services, in particular for Medi-Cal patients. UC Health provided services outside UC-owned and operated facilities. UC clinicians and provided care to Medi-Cal patients at county and community hospitals, and in collaboration with FQHCs. One example was UC Davis Health's partnership with WellSpace Health in Sacramento to increase access to specialty services.

Each UC Health campus had a local strategy for addressing community needs, but all were pursuing the development of ambulatory care networks, expanding services, partnering with other providers, and addressing capacity constraints by acquiring and partnering with struggling and distressed hospitals.

Expanding services for Medi-Cal patients presented many challenges to UC's medical centers. The foremost challenge was capacity. The demand for services by all patients far exceeded the supply that UC Health could offer. UC hospitals were operating at or over capacity, and there were long wait times for specialty care. UC's competitors were reducing services for Medi-Cal patients and directing these patients to UC. UC Health lacked post-acute care placement for patients. Health plan processes were also a challenge, including the perennial issue of reimbursement. It was challenging to scale up ambulatory services quickly enough to meet patient needs.

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Dr. Rubin observed that there was a misconception about UC Health's work to provide care for these patients. UC Health wished to serve these patients and a priority was to create partnerships with the State, counties, and FQHCs to achieve this.

Committee Chair Pérez recalled that about one-third of Californians were Medi-Cal patients. He asked what additional percentage of Californians were Medicare patients. UCLA Health Chief Strategy Officer Santiago Muñoz responded that about 4.3 million Californians were Medicare patients. Committee Chair Pérez asked if there were therefore approximately 20 million patients in the two programs. Mr. Muñoz responded in the affirmative.

Committee Chair Pérez asked if the inpatient mix at UCLA Health had a greater percentage of public payers than in the population at large. Mr. Muñoz responded in the affirmative.

Committee Chair Pérez referred to Dr. Rubin's comment about the difference between the role UC Health plays and the perception of that role. At the same time, the payer mix at this campus, UCLA, had a greater proportion of public payers than the state at large. UCLA Health President Johnese Spisso explained that the percentage of Medi-Cal patients in Los Angeles County was higher than in UCLA's payer mix, but for the geographical areas that UCLA Health serves, UCLA's percentage was higher, as stated by Mr. Muñoz.

Regent Park asked if this perception about UC Health was held only in Sacramento or beyond, and if UC had not made any efforts to close the gap between perception and reality. Ms. Ma responded that this perception was held not only in the State government but beyond. She believed that this understanding was based on a past reality. UC Health was now serving more Medi-Cal patients. There was a continuing effort to inform people about UC Health's current activities and goals and UC had dedicated much time to communicate with legislators, legislative staff, and the Governor's administration over the past year. UC Health is a complex organization, and it is not simple to communicate about its many missions, and how UC accomplishes and finds resources to support these missions.

Regent Ellis reflected on the importance of stewarding UC's relationships in Sacramento. Dr. Rubin responded that UC Health was actively working in this as part of its stakeholder engagement strategy.

Regent Raznick noted that UC Health, among other goals, sought to increase efficiency in order to reduce costs. He asked if efforts to increase efficiency were being made across the institution. Dr. Rubin responded that there was an entire workstream dedicated to economy in UC Health's strategic plan. As one moved toward capitated health plans, market incentives were pushing for greater efficiency.

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6. **ACCESS TO SEXUAL ASSAULT FORENSIC EXAMS, OTHER MEDICAL OPTIONS, AND HOLISTIC SUPPORT AT THE UNIVERSITY OF CALIFORNIA FOR VICTIMS OF SEXUAL ASSAULT**

[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 introduced this discussion, which followed up on a discussion about medical options for victims of sexual assault at the University at the October 2023 meeting. In response to concerns about access to sexual assault forensic examinations (SAFE exams) and responses to sexual assault on campuses, the Office of the President (UCOP) reviewed medical care options and support services for survivors.

Systemwide Deputy Title IX Director Isabel Alvarado Dees recalled that, in October 2023, she and her colleagues had shared information about the three types of services available for survivors of sexual assault at the campuses. This included medical treatment, which is available at each student health center. The October 2023 presentation also outlined the options for students and other community members to access investigative and non-investigative SAFE exams. There were specific deliverables or follow-up items raised in that discussion, and these have guided the Systemwide Title IX Office's (Office) work since then in three general areas: improving the accuracy and availability of information for survivors, opportunities for engagement with student leadership and student advocates, and improving access to services. In order to improve the accuracy and availability of information, the Systemwide Title IX Office engaged in a complete review of digital, virtual, and other content at the campuses, prioritizing three items of information, based on student feedback: the availability of SAFE exams at no cost and other medical treatment following sexual assault, the availability of transportation to access these services at no cost, and the availability of support from confidential advocates. The Health Services Committee had requested two deliverables: an updated chart showing the full array of resources, which was included in the current background materials; and a map of the sites where individuals can access SAFE exams on the campuses. With respect to the second request, the Office received feedback from community advocates, from the campus and broader community, indicating that creating such a document would create the potential for physical harm or continuing risk to survivors and those providing services to survivors. The Office accepted this recommendation not to create a map resource.

The Office worked to engage with students and student advocates, including work with a student advisory board to gauge their interest in developing a public awareness campaign about SAFE resources. The board was enthusiastic about this idea and developed a public awareness campaign. The Office worked with the UC Student Association (UCSA) to preview this campaign, and UCSA agreed to work on distribution. Students had additional recommendations for improving access to resources and information, such as recommending that UC include information about SAFE resources in mandatory student training programs. The Office accepted this recommendation and was implementing it.

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With respect to improving and increasing access to SAFE sites, the Office was able to confirm and recommend supporting the ongoing participation of Campus Assault Resources and Education (CARE) directors in the local county sexual assault response teams. This was a key point because district attorneys' health officials are the individuals with the agency to determine where and how SAFE services are provided. UC's focus of advocacy should be the local sexual assault response teams, which are county-based. The Office has explored options to provide SAFE exams on campus. Pilot programs at UC San Diego and UC Irvine have begun to offer SAFE services on campus. At UCSF and UCLA, affiliate hospitals provided these services. UC Merced had developed a pilot program.

UC Merced Vice Chancellor Charles Nies recalled that the County of Merced was limited in some of the health services it provided. There was currently no SAFE service in the entire county, nor to the north in Stanislaus County. Currently, UC Merced students needing these services were transported to Fresno, an hour's drive away. UC Merced had been working with its County partners to determine how to provide this service not only for students but for all community members. The solution was a group of forensic nurses from Fresno who had begun their own forensic nurse service program and had agreed to partner with UCM and Merced County. UCM had worked with Dignity Health to locate a space. Mr. Nies anticipated that this exam site would be available beginning on May 1. UCM worked to ensure the County's support for this program and was also working with the Sheriff's Office, local law enforcement, and the District Attorney's Office. It was important to gain the confidence of these individuals in the service UCM was providing as they oversee the sexual assault response team services in the county. Mr. Nies stressed that this was a pilot program, and that the campus was still reviewing the relationships between all of these entities and the ability to provide this service for all survivors of sexual assault in Merced County.

Ms. Dees concluded by noting that this was Sexual Assault Awareness Month, which had begun 23 years prior as a result of advocacy by students and survivors. Student advocacy had improved UC's programs.

Student observer Kylie Jones recounted incidents she had observed, such as the case of two 18-year-old women who were hospitalized after being drugged with fentanyl-laced substances at a fraternity party. This caused her to ponder how adequate funding for CARE offices could have made a difference. With comprehensive education on drug-facilitated sexual violence, these women might have been better supported and protected, including by bystanders who might have been able to recognize what was occurring and intervene. Clear resources for survivors might have alleviated daunting and isolating aspects of their recovery journey. This was only one of countless stories of sexual violence and harassment on UC campuses and it highlighted the critical need for increased funding for CARE offices. Improving access to SAFE exams was commendable, but survivors needed ongoing support beyond medical assistance. CARE confidential advocates played a vital role in providing holistic care but were often overburdened and lacked adequate resources to meet the demand for their services, especially after hours. Without sufficient support, staff turnover would increase. Investing in primary prevention efforts was essential to

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reduce sexual violence on campus. CARE offices required additional funding to expand their educational programming and outreach initiatives.

Ms. Jones urged the Regents to implement the recommendations outlined in the 2020 CARE needs assessment regarding staffing and budget allocations, and to employ at least one full-time advocacy staff member and one full-time prevention staff member per 12,000 students. She also supported an allocation of $2.50 per student annually for prevention efforts. Permanent institutionalized funding was necessary to sustain these vital services, rather than reliance on temporary grant funding, which could jeopardize continuity of care. By adequately funding CARE centers, UC would not only be addressing the immediate needs of survivors but would also be working toward a more equitable and just campus environment. There was strong grass roots support among students for these services and for adequate support for CARE offices.

Regent Ellis thanked the Merced campus for its efforts to provide SAFE exam services for students and county residents.

Regent Raznick observed that the intention of this item was to create clarity that would lead to understanding, awareness, access, and support. This was a complex issue, and the University had made substantial progress.

The meeting adjourned at 2:35 p.m.

Attest:

Secretary and Chief of Staff

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