The Regents of the University of California

HEALTH SERVICES COMMITTEE
January 23, 2025

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, Park, 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, Hernandez, and Sarris, Regents-designate Brooks and Komoto, Faculty Representatives Cheung and Palazoglu, Secretary and Chief of Staff Lyall, General Counsel Robinson, Provost Newman, Executive Vice President and Chief Operating Officer Nava, Senior Vice President Turner, Vice President Kao, Chancellors Frenk, Gillman, May, and Yang, and Recording Secretary Johns

The meeting convened at 12:20 p.m. with Committee Vice Chair Sures presiding.

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

Upon motion duly made and seconded, the minutes of the meeting of November 12, 2024 were approved, Regents Batchlor, Chu, Drake, Park, Reilly, and Sures voting "aye."[1]

2. **APPROVAL OF APPOINTMENT OF AND COMPENSATION FOR MICHAEL CONDRIN AS INTERIM CHIEF EXECUTIVE OFFICER, UC DAVIS HEALTH AS DISCUSSED IN CLOSED SESSION**

The President of the University recommended that the Health Services Committee approve the following items in connection with the appointment of and compensation for Michael Condrin as Interim Chief Executive Officer, UC Davis Health, Davis campus:

A. Per policy, the appointment of Michael Condrin as Interim Chief Executive Officer, UC Davis Health, Davis campus, effective February 15, 2025 through January 31, 2026 or until the appointment of a new Chief Executive Officer, UC Davis Health, Davis campus, whichever occurs first.

B. Per policy, continued appointment of Michael Condrin as System Chief Operating Officer and Chief Administrator, UC Davis Medical Center, Davis campus.

C. Per policy, an annual base salary of $1,062,600 during Mr. Condrin's appointment

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

as Interim Chief Executive Officer, UC Davis Health, Davis campus, during a transition period from January 27, 2025 through February 14, 2025, and during a second transition period for up to two months following the start date of a new Chief Executive Officer, UC Davis Health, Davis campus. At the conclusion of the second transition period, Mr. Condrin's annual base salary will revert to his annual base salary in effect as of January 26, 2025 ($833,600) plus any adjustments made under the UC Davis salary program during the interim appointment and/or transition periods.

D. Per policy, continued eligibility to participate in the Short Term Incentive (STI) component of the Clinical Enterprise Management Recognition Plan (CEMRP) remaining at the Chief Operating Officer position level with a target award of 15 percent of base salary ($159,390 during the interim appointment) and a maximum potential award of 25 percent of base salary ($265,650 during the interim appointment), subject to all applicable plan requirements and Administrative Oversight Committee approval. Mr. Condrin will not be eligible to participate in the Long Term Incentive (LTI) component of CEMRP. Any actual STI award will be determined based on performance against pre-established objectives.

E. Per policy, continuation of standard pension and health and welfare benefits and standard senior management benefits (including eligibility for senior management life insurance and, after five consecutive years of Senior Management Group service, eligibility for executive salary continuation for disability.)

F. Per policy, continued eligibility to participate in the UC Employee Housing Assistance Program, subject to all applicable program requirements.

G. Mr. Condrin will continue to comply with the Senior Management Group Outside Professional Activities (OPA) policy and reporting requirements.

The compensation described above shall constitute the University's total commitment until modified by the Regents or President, as applicable under Regents policy, and shall supersede all previous oral and written commitments. Compensation recommendations and final actions will be released to the public as required in accordance with the standard procedures of the Board of Regents.

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

Chancellor May briefly introduced the item. Committee Vice Chair Sures asked about the salary's position in its Market Reference Zone (MRZ). Executive Vice President and Chief Operating Officer Nava responded that the base salary was at the 25th percentile of the MRZ.

Upon motion duly made and seconded, the Committee approved the President's recommendation, Regents Batchlor, Chu, Drake, Park, Reilly, and Sures voting "aye."

3. **REMARKS OF THE EXECUTIVE VICE PRESIDENT OF UC HEALTH: ROADMAP TO STRENGTHEN THE SAFETY NET PARTNERSHIP BETWEEN UC HEALTH AND THE STATE OF 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 recalled that one of UC Health's priorities was work and partnership with the State on Medicaid. UC Health's vision as an organization was essential to the lives of people across California. In discussions among UC Health chief executive officers, vice chancellors, and others, four key road map elements have emerged regarding the safety net partnership with the State. First, UC Health must remain nimble in an evolving Medi-Cal landscape and emerging challenges. Second, there were opportunities to build on UC Health's unique Medi-Cal contributions. Third, UC Health would sustain and expand its commitments, and the fourth element was the alignment of necessary State and community resources for UC Health to fulfill its mission.

California has effectively expanded coverage through the Medi-Cal program, and one out of every three Californians was enrolled in the program. The Medi-Cal expansion population alone, over five million people, was larger than the entire Medicaid programs of almost every state in the country. This made California uniquely vulnerable at times when there were threats with respect to financing, disenrollment, and eligibility. The 14.7 million Medi-Cal members represented the entire life course from birth to elderly people in nursing homes. These members were often characterized incorrectly. Four out of every five Medi-Cal members resided in homes where individuals are employed. Dr. Rubin reflected on his own experience with Medicaid patients, such as young single mothers who often worked two jobs to take care of their children, young people with complex disabilities such as cerebral palsy, and young adolescents at a very impressionable time of life, and who were now dealing with stress factors in the wake of the COVID-19 pandemic, a fact which was reflected in a significant mental health crisis. Medi-Cal services for these patients, particularly through the CalAIM program, were critical. Many UC students were enrolled in Medi-Cal. Dr. Rubin recalled the case of a young adult with a congenital heart disease as a child who was lost to care for 20 years until the expansion of Medicaid through the Affordable Care Act and other patients who were able to reconnect to care after the expansion of Medicaid and so prevent what might have been disastrous situations. Many elderly people were struggling to live in a state like California with a high cost of living and many had dual coverage, with Medi-Cal and Medicare.

There were currently many challenges in the healthcare environment in many states, but particularly here in California: hospital closures, shortages of behavioral health providers, primary care providers, and pediatric specialists, and overcrowded emergency departments. California had done a good job of drawing down federal funding to support Medi-Cal expansion. California healthcare providers have become increasingly dependent on federal funding as well as provider taxes or fees to pay the State's share to draw down federal dollars. In a new federal administration in which the amount of support was up for debate, and due to provider taxes, not only the State and the General Fund were susceptible

to cuts in Medi-Cal, but also UC Health.

Even with all the ways in which UC Health tried to secure federal funds, UC Health did not cover the cost of care provided. UC Health currently provided a $1.3 billion community benefit in uncompensated Medicare expense. This made it difficult to sustain operations, let alone to contemplate further growth. Nevertheless, UC Health had a sense of mission which differentiated it from other providers around the state. Over the last year, Dr. Rubin and his team had focused on strengthening State and community partnerships, considering how to position UC Health's unique capabilities and how to optimize a special relationship with the State in interdisciplinary health workforce development.

Dr. Rubin commented that the contributions of UC Health to the State and people of California were not always correctly characterized or understood. UC Health comprised not only the hospitals and medical centers, but 21 of the world's best health professional schools, their faculty, and practice groups. These individuals extended far and wide beyond UC's own facilities into other locations with other hospital and health system operators, such as the Department of Veterans Affairs (VA), county and community hospitals, and Federally Qualified Health Centers (FQHCs). There were always complex negotiations with Medi-Cal-managed care plans to support this work.

UC Health's priorities were clearly aligned with Medi-Cal's priorities. Medi-Cal and the CalAIM program had three primary components: to improve access and quality, address population health needs, and strengthen the health workforce. The University was a critical partner for the State in achieving these goals.

UC Health was struggling to sustain the provision of inpatient care to Medi-Cal patients; to augment local primary care structures, in a situation of health workforce shortages affecting Medi-Cal, UC Health, and the state; and to provide backstop emergency department services when other facilities are closing, and other provider networks are limited. Dr. Rubin outlined activities UC Health wishes to pursue but could not in a situation of $1.3 billion in losses and without additional State support: increasing access to specialty care at UC and partner facilities; connecting patients to Medi-Cal resources, such as through the State's Enhanced Care Management benefit; strengthening the behavioral health infrastructure and workforce; and training the future Medi-Cal workforce. UC Health trainees often remain and work in regions near the UC location where they have received training.

The University of California was the second largest provider of inpatient care for Medi-Cal enrollees. There were other health systems with extensive capacity but that did not take on a similarly disproportionate share of patients. If one takes a more inclusive view of UC Health faculty and includes select health partners fully staffed by UC clinicians, UC was the largest provider, through its faculty, of inpatient care for Medi-Cal members across California.

UC Health's primary care strategy has evolved. UC now contracted with Medi-Cal health plans in all counties in California. UC Health delivered specialized primary care services

and was expanding its footprint where possible, such as in community clinics and FQHCs.

With respect to overcrowding in emergency departments, Dr. Rubin noted that there were large teams at each location examining how to better transition patients out of emergency departments. There was an opportunity through the CalAIM program and its investment in Enhanced Care Management resources to better connect with community resources and coordinate patient handoffs day to day in order to reduce pressure on emergency departments. Regardless of the funding environment, coordinating patient handoffs would continue to be an important part of UC Health's strategy.

UC Health makes significant efforts daily to expand access to specialty care in UC and partner facilities. The University has made efforts to acquire distressed hospitals and address challenging situations when other entities have stepped away. UC was expanding telehealth and e-consultation services, and its workforce programs provided unique value in developing the health workforce in underserved regions of the state.

Dr. Rubin raised the question of how UC Health's contributions and potential contributions match up with a reimagined partnership with the State. One important point was that when UC Health steps up and takes on problems, other systems respond by stepping away. There was a need to ensure that the burden is shared among different health systems. There was a need to enforce health plan accountability, timely payments, and appropriate rates, and a need to cover the expenses of care, given that the reimbursement UC received for its care for Medi-Cal patients was well below the cost of this care. There was a need to maximize funding for training programs, such as UC's Programs in Medical Education (PRIME), which address health disparities, and a need to optimize behavioral health partnerships. Dr. Rubin stressed that hospitals that care for a disproportionate share of Medi-Cal patients should have access to low-interest capital to meet the State's seismic safety requirements. This was especially relevant for UC Health, given the number of recent hospital acquisitions and the size of the system. Dr. Rubin concluded by underscoring the University's ability to partner with the State on Medi-Cal goals and the need for effective advocacy.

Committee Vice Chair Sures observed that UC Health would have to review its payer mix systemwide. The University had one of the greatest healthcare enterprises in the U.S., but if current trends continued, UC would not be able to afford to maintain it. Dealing with the payer mix so that UC Health can treat the greatest number of patients and patients with the greatest needs, while remaining able to recruit and retain the best faculty and staff, would be an enormous challenge. The overcrowding of emergency departments was another severe challenge. UC would have to work with State partners and partners in other hospital systems to ensure that the work of UC Health is sustainable.

President Drake expressed agreement about these challenges: to decompress those parts of UC Health that were overwhelmed, and to maintain quality and progress while dealing with the under-reimbursement that came from having many patients with government insurance or uninsured patients. He hoped that UC Health would be a leader in efficiencies and effectiveness.

Regent Park asked about the difference between how the State sees UC Health and how UC Health would like the State to see it. Dr. Rubin responded that UC Health was trying to recraft its relationship with the State. It was important that, in meetings with the State, all parties have the same frame of reference regarding UC capabilities. Sometimes there have been criticisms of UC medical centers, but these discussions have lacked awareness of UC faculty and staff practicing in other locations including FQHCs and with other community partners. Dr. Rubin believed that there was a need to make people aware of how complex the UC Health system is and what its capabilities are.

Regent Reilly asked how much the Medi-Cal population had increased systemwide over the last five to ten years. UCLA Health Chief Strategy Officer Santiago Muñoz responded that over the last ten years, since the Affordable Care Act and the expansion of eligibility, each location had likely seen an increase in utilization between 35 and 50 percent.

Regent Reilly asked where the largest growth was occurring and where in the state one expected the greatest expansion to occur in the next five years. Dr. Rubin responded that growth was occurring all over the state. The two largest growing populations were the Medicare and Medi-Cal populations. At one of the UC Health institutions this year, this population increased by three percentage points. All the medical centers have analyzed the financial impact of one or two percentage increases in this patient population and the impact on the teaching mission. The precise figures were in the annual financial report, but this did not take into account UC faculty practicing in partner facilities, so the total percentage was in fact higher than reported in the annual report. Mr. Muñoz added that, beyond percentages and the share of Medi-Cal patients, it was also important to consider the acuity of patient conditions and the cost of this care. There has been a dramatic increase in the number of children covered by Medicaid.

Regent Reilly asked if it was the case that the systemwide growth had been primarily due to the various expansions of Medi-Cal over the years. Dr. Rubin responded that, while the Medi-Cal expansion certainly contributed to this growth, even before the expansion, UC Health cared for a disproportionate share of uninsured individuals. The economics of California were moving toward a situation with a larger percentage of government payers, beyond this expansion itself.

Regent Batchlor, the Chief Executive Officer of Martin Luther King Community Healthcare, observed that her health system did not have a choice regarding which patients to treat and payer mix. She requested clarification of Dr. Rubin's comment to the effect that if UC Health steps up to a task, other entities will step back. She asked if this meant that UC should not step up to these responsibilities and stressed that behind these patient statistics, there were human beings without access to higher levels of care they needed. With respect to the wish to recruit and retain the best talent, Regent Batchlor reported that she was increasingly hearing from younger physicians that they want to work in a health system with a clear commitment to serving underserved communities. In her view, this was another compelling reason for UC Health to expand its footprint in Medi-Cal. Dr. Rubin responded that UC Health was stepping up, and all the UC medical centers were developing their Medi-Cal strategies while trying to fund education and research. UC Health location

chief executive officers and vice chancellors were balancing a number of critical priorities, any of which might collapse. He stressed that the UC schools of medicine were nimble. UC Health was working to increase its programs at UC Riverside and UC Merced. There were a number of nonprofit hospitals who were not stepping up to these responsibilities, and the State should hold them accountable in some way. Everyone needed to contribute to network adequacy and address the problem of overburdened emergency departments.

Regent Leib related his own experience of the volume of patients in the emergency department at UC San Diego. UC Health cared for many people, and the question of paying for this care and the payer mix would be an ongoing challenge.

UCLA Health Sciences Vice Chancellor John Mazziotta commented that academic health centers have many more missions than their competitors have, including research, education, patient care, and community engagement. The only one of these that provides funding is clinical care. This mission and its profit margin had to cover the cost of everything else. UC Health's competitors did not have these concerns. They were concerned with clinical care quality and making money. Academic health systems were under enormous strain to generate enough margin to cover all the other missions that were either unfunded or underfunded. If the margin is eroded by payers who provide insufficient reimbursement for the cost of providing care, all the other missions are in jeopardy.

Regent Chu referred to a chart displayed earlier showing that UC Health was the second largest provider of care to Medi-Cal patients in terms of inpatient days, while Dignity Health/CommonSpirit (Dignity) was the largest provider. UCSF had acquired Dignity facilities in San Francisco. She asked if this was occurring across California and if this was a reason for concern, since this might be a sign of things to come. She asked how UC Health would hold other entities accountable to be part of the solution to providing care for Medi-Cal patients. Dr. Rubin responded by noting that not all nonprofit hospitals were the same. Dignity did an impressive job of caring for low-income patients across the state and faced some of the same financial challenges as UC Health, although it did not have to support an academic mission. UCSF Health Chief Executive Officer Suresh Gunasekaran stated his view that Dignity was committed to trying to address this issue, which in some ways was a question of mathematics. If a hospital system does not receive State or County funding, it must treat other patients who cross-subsidize uncovered costs. Dignity was unable to accomplish this in San Francisco. A concern for UCSF was that many hospitals, not just Dignity hospitals but even safety net hospitals, would be unable to meet the demands for patient care and that UCSF hospitals would have more Medicaid patients than San Francisco General Hospital. UCSF physicians at UCSF and at San Francisco General Hospital were seeing that the community needed more than UCSF could finance. UCSF sees all patients regardless of their ability to pay. UCSF did not have an explicit plan to work on payer mix but a plan to cover costs in order to have the maximum community impact. The Regents can help medical centers to navigate the complex funding situation. A major strain for UCSF was not just the emergency department but the large number of transfers from other hospitals for complex care. The financial instability associated with meeting these needs was overwhelming the desire to have an impact. UCSF did not have sufficient space and staff and had to make its funding go further. Mr. Gunasekaran stressed

the medical centers' need for a financial solution.

Student observer Joselen Contreras addressed the following discussion item, "Federal and State Health Policy Landscape." She remarked that the current moment was a time that called for courage, clarity, and bold action. The University must reaffirm its unwavering commitment to equity, inclusion, and the well-being of all in its community. Recent executive orders at the federal level to end birthright citizenship, deport residents en masse, and roll back protections for LGBTQIA communities were direct attacks on UC values. While these executive orders might not immediately disrupt the UC Health system, they underscored the challenges UC would face with federal legislation. The U.S. presidential administration's proposed reinterpretation of the 14th Amendment of the U.S. Constitution challenged birthright citizenship, which has been a cornerstone of national identity. Removing this right would not only disenfranchise countless individuals but also cast a shadow of fear and instability across UC campuses. For the 83,000 undocumented students in California, including many in the UC system, this policy sent a chilling message. When healthcare policies are weaponized, Medicaid eligibility is tightened, Medi-Cal funding is reduced, and preventative care is deprioritized, it is these same students and their families who bear the brunt of these harmful decisions. LGBTQIA individuals would face a tidal wave of legislation seeking to deny them basic rights. Gender-affirming care, a proven necessity for improving mental health and saving lives, was under attack. Ms. Contreras stressed that the mental and physical well-being of LGBTQIA and undocumented students was non-negotiable, and the Health Services Committee had the power to ensure that these students feel safe, affirmed, and valued within the UC system. To fail in this regard would be a betrayal of the very mission of the University.

Funding from Proposition 35 provided an opportunity to strengthen UC's healthcare system, improve Medi-Cal medical provider rates, and expand graduate medical education. The University must ensure that Proposition 35 funds are managed with oversight and address intended purposes. UC Health must be a strong voice against policies that undermine birthright citizenship, restrict Medicaid access, and target gender-affirming care; invest in preventative healthcare resources, expand healthcare initiatives focusing on preventative care to improve long-term outcomes, especially when budgets are constrained; leverage Proposition 35 effectively, prioritizing closing healthcare access gaps, and track this process through measurable outcomes and hold decision-makers accountable through transparent oversight mechanisms; and engage health sciences students as stakeholders and involve student voices in shaping healthcare policy and resource allocation to ensure that UC Health actions reflect the lived experiences of those most affected. Ms. Contreras urged UC Health to boldly uphold UC values of equality, inclusion, and justice.

4. **FEDERAL AND STATE HEALTH POLICY LANDSCAPE**

[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.]

Associate Vice President Tam Ma commented that this was a busy week and month in

Sacramento and Washington, D.C. Multiple teams at the Office of the President (UCOP) were tracking and gathering information to understand how changes that were being announced would affect UC Health's teaching, clinical care, and research mission and how they would affect people in UC communities. UC Health has been working closely with the Office of Federal Governmental Relations to communicate with federal policymakers and to meet with the State's two U.S. senators and members of Congress. UC Health was also working closely in coalition with trade associations to magnify and amplify their collective voice about the impacts of various proposals being discussed in Washington and was updating fact sheets and communication tools to better communicate and reflect the impact of UC Health. Ms. Ma and her colleagues were also in close contact with the academic health centers to give them timely information about these events so that they can assist in advocacy efforts.

This week had been a week of transition at the federal level. The new U.S. president was inaugurated on January 20. Republicans controlled the White House and had slim majorities in the U.S. House of Representatives and Senate. The president over the last few days had issued a number of executive orders and directives that would affect longstanding law and policy and the operations of federal agencies. One of the top priorities of the president and the congressional leadership was to extend the 2017 tax cuts that would expire later this year. To do this, they would need to find ways to cut about $4 trillion in spending and they hoped to do this through the budget reconciliation process, which made it easier to make these cuts and extend tax cuts because it only required a simple majority vote in the Senate rather than being subject to filibuster.

As Executive Vice President Rubin mentioned in the preceding discussion, Medi-Cal is an important program for the health and well-being of Californians. One-third of Californians receive coverage from the State Medi-Cal program, which is predominantly funded by federal funds. Ms. Ma underscored the fact that two-thirds of all federal funds that come to California flow to the Medi-Cal program.

With respect to healthcare financing, many ideas were being proposed to cut healthcare programs to achieve $4 trillion in spending cuts and extend tax cuts. Ms. Ma outlined four such ideas. The first was to reduce Medicaid spending by $2.3 trillion. These proposals included instituting per capita caps on federal government contributions to Medicaid spending or lowering the federal matching rate for Medicaid programs and limiting state-directed payments. These proposals would drastically reduce the federal funds available for Medicaid and shift the costs of providing care from the federal government to states and providers such as UC Health. UC medical centers and county health systems were particularly vulnerable because they rely heavily on federal supplemental payments to help get closer to meeting costs. UC has self-financed the non-federal share of those supplemental payments.

The second idea was to cut Medicare reimbursement for services that are provided in hospital outpatient departments or so-called "site neutral payments." The third idea pertained to the 340B Drug Pricing Program, which provides safety net providers with discounts on prescription drugs. There have been efforts in the past to limit these discounts.

In the last year, UC Health was able to generate about $1.2 billion in savings due to the 340B Program, so any efforts to restrict these discounts would have a significant impact on UC.

The fourth idea was to cut funding for the National Institutes of Health (NIH). The University of California was the largest recipient of NIH funding, receiving about $2.6 billion annually. Most of these funds are routed to the UC Health professional schools and academic medical centers. Over the last day or two, there had been pauses in communications and meetings of the NIH and other federal agencies. UCOP was trying to understand what was taking place and communicate this to UC faculty and researchers.

While these ideas had not yet come to fruition, if these cuts were to materialize, they would deeply affect the California State budget and force the State to make difficult decisions about how to balance the budget in light of reduced federal funding. There might be significant cuts to Medi-Cal eligibility, the benefits provided through the program, and provider rates. Significant cuts to NIH funding would jeopardize UC Health's ability to deliver research and treatments and cures for illnesses and diseases. The proposed cuts would also jeopardize UC's ability to sustain patient services and expand access to care.

The various executive actions issued by the new president over the last few days affected issues including immigration, anti-discrimination, gender identity, health equity, and the operations of federal agencies including the U.S. Department of Health and Human Services and the NIH. UC Health was tracking and reviewing these executive actions to assess their impact on UC Health's mission as well as on faculty, staff, students, and patients.

The State government was also very busy at this moment, in particular due to the ongoing wildfires in Southern California. Governor Newsom was scheduled that day to sign a $2.5 billion wildfire relief package to help Los Angeles County recover from the fires. There was also an agreement between the Legislature and the Governor to provide funding to support litigation challenging federal actions. Earlier in the month, the Governor proposed a balanced budget that would maintain Medi-Cal eligibility and benefits and would continue some provider rate increases that began in 2024. The State would also be working on implementing Proposition 35, approved by California voters in November 2024. This initiative was expected to generate an additional $2 billion to $5 billion a year from a tax on managed care organizations, and these funds would primarily support Medi-Cal provider rate increases and graduate medical education programs. The University did not yet know how these provider rate increases would be implemented. UC Health would certainly benefit from provider rate increases and engage in the stakeholder process, which would begin soon.

UC Health, in collaboration with the Offices of Federal and State Governmental Relations, would continue making the case to State and federal lawmakers to help them understand that federal dollars make it possible for UC Health to provide care to patients from 91 percent of California's zip codes. Every California elected official had constituents who are served by UC Health and reached by its teaching, research, and clinical care mission.

UC Health would continue advocating to sustain funding for its healthcare programs and continue supporting its research and teaching mission. This year, UC Health would sponsor State legislation to protect reproductive health research data and would also seek funding for UC Programs in Medical Education (PRIME) in schools of dentistry, pharmacy, and veterinary medicine as well as State resources to support behavioral healthcare infrastructure and workforce available through Proposition 1, passed by voters in March 2024, and the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) waiver, recently approved by the federal government.

Regent Reilly referred to new threats at the federal and State level and asked how UC Health was working differently now than a year ago in the area of policy and governmental relations. She asked if UC Health was hiring more people or considering different resources and how UC Health was addressing these potential threats. Ms. Ma responded that UC Health and the Offices of Federal and State Governmental Relations were coordinating more closely than usual to ensure that all teams understand the discussions currently taking place at different levels of government and are equipped and prepared to relay information to policymakers. UC Health leaders were making more frequent visits to Washington, D.C. and Sacramento to augment the work of the Offices of Federal and State Governmental Relations.

Regent Park observed that the University would have to guard against many potential impacts. She asked about UC Health's financial modeling regarding direct and indirect impacts of actions the new U.S. federal administration might take. Some actions might significantly weaken the State's ability to provide financial support for UC Health's mission. Dr. Rubin responded that UC Health was working with partners at the California Association of Public Hospitals and Health Systems (Association) on this type of modeling, especially regarding proposed cuts to the federal share of funding for Medi-Cal. In his view, the two largest threats to the University were threats to Medi-Cal and the NIH.

Regent Park stated that it appeared that the Association was taking the lead in financial modeling on behalf of public hospitals in California. Dr. Rubin confirmed this. The Association regularly works with UC Health on supplemental payments to support UC's Medi-Cal program. Ms. Ma added that UC Health works closely with the Association because UC Health is financed in the same way as county hospitals and so wishes to demonstrate their collective impact. Within UC Health, there was work ongoing with reimbursement directors and others to gather information and develop estimates of possible impacts to UC medical centers. Dr. Rubin noted that there would be impacts directly on UC Health as well as impacts on its public health system partners. Modeling by the Association suggested that about four to six public hospitals in California might close if some of the more significant proposals were adopted. Many of these facilities were in areas of California with moderate Republicans or Democrats in office who would be immediately threatened by some of these proposals. Vulnerable communities in the Central Valley and Inland Empire would be affected by these proposals.

Regent Park stressed the importance of tracking the possible impact of these proposals at

the regional and even the district level, and the direct impact on communities, whether or not there is a direct impact on UC Health. Ms. Ma expressed agreement and reiterated that every California elected official had constituents who would be affected. As many as 63 percent of residents in some districts in California were covered by Medi-Cal. Policymakers needed to be reminded of this fact. UC Health was in discussions with a number of organizations that were coordinating this information. The California Health Care Foundation had posted information on its website on the district-by-district impacts of proposed cuts to Medicaid. UC Health and these organizations were working together to share information and use publicly available data to amplify the messages that policymakers needed to receive.

Regent Park commented that UC Health seemed to be better equipped to deal with the COVID-19 emergency than with the current situation, which was an emergency of a different order, but no less an emergency that required collaboration with the State and all involved parties. There were many troubling proposals, and it might be difficult to keep track of possible impacts.

5. **ADVANCING EQUITABLE MATERNAL CARE: AN UPDATE FROM THE UNIVERSITY OF CALIFORNIA HEALTH CLINICAL QUALITY COMMITTEE**

[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.]

This discussion item was deferred.

The meeting adjourned at 1:30 p.m.

Attest:

Secretary and Chief of Staff