The Regents of the University of California

HEALTH SERVICES COMMITTEE
May 13, 2025

The Health Services Committee met on the above date at the UCSF Mission Bay Conference Center, San Francisco campus.

Members present: Regents Batchlor, Chu, Leib, Makarechian, Matosantos, Park, and Sures; Ex officio member Reilly; Executive Vice President Rubin; Chancellors Frenk, Gillman, Hawgood, Khosla, May, and Wilcox; Advisory member Ong

In attendance: Regents Anguiano and Beharry, Regents-designate Brooks and Komoto, 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, Senior Vice President Turner, and Recording Secretary Johns

The meeting convened at 3:00 p.m. with Committee Chair Sures presiding.

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

Upon motion duly made and seconded, the minutes of the meeting of March 18, 2025 and the joint meeting of the Health Services Committee and the Governance Committee of March 19, 2025 were approved, Regents Batchlor, Leib, Makarechian, Reilly, and Sures voting "aye."[1]

2. **UC HEALTH STRATEGIC PLAN**

[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 prefaced the discussion by thanking President Drake and recognizing him as a valuable mentor and colleague. He recalled that President Drake had once shared with him "The Enigma of Arrival," a book by Vidiadhar Surajprasad Naipaul (1932-2018). This is a meditative work that reflects on arrival in a new place, how places never really change, but what makes them unique are the people who pass through them.

The UC Health strategic plan was being developed before Dr. Rubin's arrival at the Office of the President and had now become more substantive. UC Health faced many challenges at this time, among them the risk of Medicaid and Medicare payment reductions, reduced federal investment in research, UC's growing role as a safety net healthcare provider, and the increasing reliance on medical center revenues to offset financial risk to the campuses.

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

Dr. Rubin reviewed progress on the five pillars of the strategic plan: State and federal engagement, network development, ambulatory access and experience, employee and student health, and data science and innovation. In the area of State and federal engagement, UC Health was working to advocate for the protection of federal health programs and working with the State to enact policies that can support UC's ability to serve Medi-Cal patients. UC Health was on the point of creating an Office of Strategic Partnerships to coordinate Medi-Cal and Medicare strategy and was developing and implementing a stakeholder engagement plan, communicating with officials in Sacramento and Washington, D.C. about the unique relationship that the State of California has with UC Health. UC Health has established systemwide governance for Medi-Cal, a rapid response team for Medicaid issues, and was partnering with Federal Governmental Relations to respond to shifts in the federal landscape.

In the area of network development, the University was placing clinical services and training programs in regions where UC has not practiced before. Dr. Rubin looked forward to the continued discussion of the development of UC Riverside Health. UC Health was assisting its campuses and locations in navigating the impacts of Medi-Cal program changes on their strategies to improve care for under-resourced communities.

Improving ambulatory access and the ambulatory patient experience was an important goal, and UC Health would measure its success on this goal in the years ahead. UC Health has established resources for clinical integration to accelerate the use of Epic electronic health records and streamline proactive care. UC Health was achieving outstanding clinical quality outcomes in population health in diabetes and blood pressure control and reducing inequities.

UC Health was partnering with Systemwide Human Resources to improve and modernize UC Health's participation in UC employee benefit plans, and partnering with Academic Affairs, UC Finance, and the campuses to improve access and affordability for UC students. UC Health has implemented stronger governance and strategy for improving the sustainability and quality of the University's student health programs.

In the area of data science and innovation, UC Health was leveraging its systemwide data resources and infrastructure to support patient care, research, and innovation. There has been an increase in the number of faculty who are accessing systemwide data for research and in the use of these data for enterprise analytics. The data have been successfully migrated to cloud-based services with bolstered cyber security resources.

UC Health was focused on a number of specific projects in alignment with this strategic plan but also had to respond to new issues. Dr. Rubin would be working with Provost Newman and her office to convene a group to discuss alternative sources of funding for research including philanthropy and industry and State investment. Physician well-being was another issue of concern. Health Sciences clinical faculty had petitioned to join the ranks of the UC Academic Senate. These petitions were not successful but have led to meaningful conversations about alternative models to ensure that clinical faculty are

appropriately represented. Dr. Rubin expected that as these discussions continue, the question of physician well-being overall would become an important systemwide goal.

Regarding the UC Health budget, UC Health understood that it was under pressure to do more with less, and its proposed fiscal year budget for 2025–26 was more than six percent lower than the prior year budget. UC Health was absorbing mandatory increases of $1.6 million, in particular for non-represented staff. The budget was reduced by $3.8 million, including some workforce reductions, to reserve room for a $1 million investment for the Office of Strategic Partnerships, to increase work in enterprise analytics, and support Epic integration. These were difficult times, and UC Health was trying to be leaner while remaining focused on its strategic framework.

Regent Beharry asked how the budget reduction in the current year compared to the budget situation in the prior year and about the 62 percent reduction in "other designated funds," shown in the background material. He asked which programs or initiatives have been funded by the other designated funds. Dr. Rubin responded that the anatomical donation program for the medical schools has been funded over the years by an extra pool of funds from the medical schools. The 62 percent referred to this, and it did not represent a large amount of money. In this budget, UC Health also reduced the application of its campus assessment fund, making significant reductions in order to shift resources in some designated funds to campus assessment funds. In this case, there was no net reduction; funds were moved into the campus assessment category.

Regent Anguiano asked about staffing. Since there was a hiring freeze and a budget reduction in full-time equivalent positions (FTE), she asked how UC Health would ensure that reductions were being made strategically so that UC Health does not lose key employees and has more staff where they are not needed. Dr. Rubin responded that there was a careful process of project management and strategic plan analysis. Dr. Rubin worked with all his direct reports to identify critical goals and priority resources, and to distinguish priority resources from resources that would be desirable but not critical for the UC Health strategic plan. There were important discussions with the locations, with chief executive officers and vice chancellors to understand what systemwide programs are successful and to ensure that UC Health does not encroach on the independence of the campuses, because they are in very competitive markets. In this dialogue, one identifies resources which are necessary, those which are not, and repositions for the future.

Staff Advisor Frías noted that UC Health was planning to spend 6.2 percent less this year and asked about the dollar amount of this reduction. Dr. Rubin responded that the absolute reduction would be about $2 million or $3 million. UC Health was still absorbing the mandatory increases for staff salaries, and there would be some additional costs for the growing use of systemwide data. The net reduction was about $2 million, but the reduction in dollar amounts or percentages might have been greater if UC Health had not made adjustments.

3. **THE 340B PROGRAM AT 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 began the discussion by identifying the greatest current funding risks to UC Health, which were to research funding and to Medicaid and Medicare funding. Medicaid was currently the subject of U.S. congressional negotiations, but Medicare was one-third of UC Health's payer mix, and the University had as much if not more exposure in Medicare than in Medicaid. With the aging population of California, UC Health was experiencing the greatest growth in its payer mix not in Medi-Cal but in Medicare. Certain areas of Medicare were critically important because UC Health was not funded to cover these expenses, and one such area was the 340B Drug Pricing Program, a discount program for pharmaceutical drugs. UC Health can use these savings to cover uncompensated care for Medicare and Medi-Cal enrollees. The savings from the 340B program were significant, and any federal intervention in the program would have a tremendous impact on UC Health's ability to carry out its mission.

Chief Pharmacy Officer Cedric Terrell explained that the 340B Program is a federal law established under Section 340B of the Public Health Service Act in 1992. It requires pharmaceutical manufacturers to sell outpatient drugs to eligible healthcare facilities at a discount, sometimes as much as 50 percent off the wholesale price. Eligible healthcare facilities or "covered entities" under the UC umbrella were the University's Disproportionate Share Hospitals (DSH) and some other clinics. Patients are eligible if they have an established relationship with a covered entity and receive services from the covered entity's healthcare providers. The discount had nothing to do with the margin paid to UC Health by Medicare or commercial payers.

The purpose of the 340B Program is to enable covered entities to stretch scarce federal resources as far as possible. UC Health can use the savings from the Program for other patient services. The Program is also intended to mitigate the effect of rising drug costs. UC Health had 18 covered entities that participate in the Program: 11 DSH, three hemophilia treatment centers, two Federally Qualified Health Centers, one children's hospital, and one Ryan White clinic. Because of the savings associated with the Program, UC Health is able to provide community benefits in the form of financial assistance for uninsured and underinsured patients, support for Medi-Cal services, subsidized care for vulnerable populations, and free or discounted medications from UC in-house pharmacies.

In fiscal year 2022–23, UC Health delivered $5.3 billion in net community benefits, including $2 billion in direct investment in services, including uncompensated hospital care for Medi-Cal enrollees, $2.4 billion in uncompensated hospital care to Medicare enrollees, and $881 million in uncompensated professional care by UC faculty to Medi-Cal and Medicare enrollees. These community benefits are enabled in part by the 340B Program.

Dr. Terrell presented a diagram showing the functioning of the 340B Program. Covered entities purchase drugs at a discounted price, dispense medication to patients, and there can

be margin generated by the reimbursement to the covered entity by insurance or the payer. The following diagram illustrated the same situation but without the 340B Program. The covered entities purchase at the retail or wholesale price, dispenses medication, and reimbursement remains the same, but the resulting margin is much smaller. UC Health did not have enough in-house pharmacies to supply prescription services to all the communities it serves and so has established contract relationships with community pharmacies, referred to as "contract pharmacies" under the 340B Program. UC Health pays a dispensing fee to these pharmacies. The value of the contract pharmacy program was that it allows UC to extend its reach to patients and retain margin.

The 340B program was overseen by the Health Resources and Services Administration (HRSA). To ensure compliance and transparency, HRSA and manufacturers may conduct audits, including audits at each relevant UC Health site. Dr. Terrell noted that there were bad actors in this space. There had been two HRSA audits at UC in the last year, and another audit was scheduled for June 2025. The community pharmacy arrangements were also subject to compliance requirements. The University conducts internal audits to ensure compliance with 340B Program requirements and prepare for external audits. UC had robust internal controls and approximately 30 full-time equivalent positions (FTE) working on 340B Program compliance. Noncompliance identified through HRSA audits can trigger significant repayments to manufacturers; therefore, UC Health wished to ensure the integrity of its program. Dr. Terrell concluded his remarks by emphasizing that the 340B Program helps UC Health offset the high cost of care for patients and allows UC to serve more people. Savings from the 340B Program are directed toward essential services like specialty care, pharmacy access, and public health initiatives that improve outcomes across California, especially in underserved communities.

Regent Makarechian referred to the diagram illustrating the functioning of the community pharmacy arrangement under the 340B Program and asked who the payer was who reimbursed the University. He asked if Medicare and Medi-Cal were payers, or only private insurance companies. Dr. Terrell responded that commercial insurance and Medicare were the payers.

Regent Makarechian asked about the logic of the arrangement from the point of view of the wholesaler or distributor. Dr. Terrell responded that this was a voluntary program. For drugs to be covered under the Medicare program, the manufacturers must allow drugs to be purchased at this discount rate. The expectation is that covered entities like UC Health use the savings associated with the 340B Program to provide services to underserved communities. Community pharmacies work with UC Health because this lowers their inventory costs and they receive a dispensing fee. UC Health wishes to work with community pharmacies because it extends UC Health's reach to more patients.

Regent Makarechian asked if all UC Health facilities were covered entities. Dr. Rubin responded that not all UC Health facilities were designated as covered entities. He noted that the diagram suggested the location of friction points. The federal government established this program to provide discounts without the need for taxpayer money. The pharmaceutical industry was unhappy that it must offer its medications at a discount as a

condition of participation in Medicare. The U.S. Congress' goal was to extend savings for federal health insurance programs to keep up with inflation. Various interests were advocating for different solutions regarding the 340B Program. UC Health was most concerned about advocacy by the pharmaceutical industry, which would prefer not to have these medications offered at a discount.

Regent Makarechian asked how much of the $5.3 billion in community benefits provided by UC Health came from the 340B Program. Dr. Rubin responded that the $5.3 billion was a cost accounting of all the services UC Health provides to Medi-Cal and Medicare members. The 340B Program generated approximately $1 billion in annual savings for UC Health.

Regent Makarechian and Regent-designate Brooks asked if and how recent executive orders by the Trump administration would affect this program. Dr. Terrell responded that at this time, the University did not know what the impact of the "most favored nation" drug pricing initiative would be. His understanding of the announcement the prior day was that it called for the development of a plan within 30 days. The potential impact on UC and the 340B Program was not known.

Regent Leib asked about the bad actors mentioned by Dr. Terrell and who might be the target of HRSA audits. In some entities within the community pharmacy program, duplicate discounts can occur, with a discount on the purchase of the drug and a rebate paid to the payer, with the manufacturer losing on both sides of the equation. Manager Amar Sharma explained that there was criticism of the 340B Program because not every covered entity was reinvesting savings in the program to help patients as UC Health did. There was also a blatant violation of the program occurring at other sites. Regent-designate Komoto, Chief Executive Officer of a 340B contract pharmacy, explained that "double dipping" occurs when an insurance company pays the eligible entity, and the entity has not notified the insurance company that it is a covered entity in the 340B Program. The pharmacy pays the same price and is not at fault. The covered entity is not appropriately identifying the situation.

4. **MEDI-CAL LANDSCAPE OVERVIEW**

[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 observed that UC Health's work as a safety net provider was predicated on the federal and State partnership for Medi-Cal, which covered one-third of the population in California. There were now threats to the University at the federal level because of UC's participation in Medicaid.

Associate Vice President Tam Ma drew attention to the fact that this year, 2025, was the 60th anniversary of the Medicaid program, which was established along with Medicare. These two programs have for 60 years protected the health and well-being of millions of American families, saving lives and improving the economic security of the U.S. Medicaid

currently covered 83 million Americans and one-third of the California population, or nearly 15 million people, including children, pregnant women, elderly adults, people with disabilities, and low-wage workers who cannot receive health coverage from their jobs. Medicaid helped to ensure that even the most vulnerable populations have access to necessary medical care, from routine checkups to long-term care. Half of new mothers in the U.S. had health coverage through Medicaid. In California, Medi-Cal was the largest purchaser of healthcare services. California embraced the Affordable Care Act and has expanded the Medicaid program. Because of these expansions, California's underinsured rate was at an all-time low at 6.7 percent, and 94 percent of Californians had health insurance coverage. This was an achievement to be proud of.

UC's academic health centers are a core part of California's healthcare safety net. UC Health delivers care to Medi-Cal patients through its medical centers and clinics, and UC providers work in community settings as well, in county and community hospitals, clinics, and Federally Qualified Health Centers (FQHCs). UC Health provides a large volume of services to Medi-Cal patients from 91 percent of California zip codes. People travel to UC medical centers from all corners of the state for specialty and inpatient care that is not available in their communities. UC is the largest provider of outpatient care and the second largest provider of inpatient care to Medi-Cal patients. UC Health service volumes have been increasing in tandem with the expansion of Medi-Cal.

Medi-Cal payments were a key source of funding for UC medical centers. Systemwide, one-third of inpatient days and 20 percent of revenue came from Medi-Cal payments. These payments help UC to fund staff, facilities, and services for all patients, not just Medi-Cal patients.

The Medi-Cal budget was large, about $175 billion this year. The federal government provided about two-thirds of this funding. The State share was financed in a number of ways, including the State General Fund, funding from local governments, including the University, and provider fees and taxes. The federal government contribution to Medi-Cal depended on the Federal Medical Assistance Percentage (FMAP), and the FMAP depended on the part of the Medicaid population being served, generally 50 percent for the traditional Medicaid population and 90 percent for the Affordable Care Act adult expansion population. Ms. Ma presented a chart showing Medi-Cal funding sources and amounts from 2006–07 to 2023–24. Over the years, as the program and enrollment have grown, the total federal payments have also increased.

As a provider, UC Health receives base rates which are negotiated with Medi-Cal-managed care plans or with the State. UC Health also receives supplemental payments, which are additional payments to offset costs, pay for services, and support quality and access goals. Currently systemwide, about 42 percent of total Medi-Cal payments were base payments while the greater share, 58 percent, were supplemental payments.

Erica Murray, President of the California Association of Public Hospitals and Health Systems (CAPH), explained that her organization, of which UC was a member, worked with UC to, among many other things, design, negotiate, and implement these crucial

Medicaid supplemental payments. The supplemental payments were necessary because the base payments did not adequately cover the costs of providing care.

Regarding threats to Medicaid, CAPH has been focused on four areas in 2025. The appropriations process was the focus in the first quarter of 2025. This was resolved with a continuing resolution that was passed through the end of the current fiscal year. Importantly, cuts to Medicaid funds for Disproportionate Share Hospitals (DSH) were delayed through the end of September. Ms. Murray stated that the federal budget reconciliation process would be the focus of her remarks, but it was also important to note two other areas, namely, federal executive actions and the release of the May Revision of the State budget, which would occur the following day.

The budget reconciliation process was now ongoing, as the U.S. House of Representatives' Energy and Commerce Committee was marking up a bill, having been instructed by the House to find $880 billion worth of cuts over ten years in its areas of jurisdiction. The current markup under consideration would propose $912 billion of cuts, including $715 billion from Medicaid. This overshooting of the goal suggested that the Committee expected changes and amendments, with some elements to be removed and new elements introduced. One was still in the early stages of the budget reconciliation process. This was a fluid process, and key issues had not been resolved, such as the State and local taxes (SALT) deduction. And while it was important to focus on the Energy and Commerce Committee markup, this was by no means the only important element.

Ms. Murray outlined some of the proposals being considered by the Energy and Commerce Committee. As Ms. Ma had mentioned, supplemental payments made up most of UC's total Medi-Cal payments. A major piece of these supplemental payments were State-directed payments, in which the State directs Medi-Cal-managed healthcare organizations to serve as an intermediary for funds provided by public healthcare systems, and were referred to as intergovernmental transfers. The public healthcare system—UC Health, a county hospital, or a public hospital—puts up an intergovernmental transfer, which is matched by the federal government and then comes back through a managed care organization (MCO) to the public healthcare system to make up the difference between the cost of care and the low base rate that is received. These supplemental payments were crucial to ensure access and quality. In 2024, the Biden administration finalized a rule allowing State-directed payments to reach the average commercial rate, acknowledging the difference between Medicaid rates and commercial insurance rates. CAPH worked with UC Health to secure an additional $1.8 billion in net increases to the State-directed payments for public healthcare systems in December 2024 and January 2025. CAPH had heard, prior to the Energy and Commerce Committee markup, that there were proposals to cut State-directed payments to Medicare levels. These payments were now above Medicare levels but below the average commercial rate. If this policy of capping State-directed payments to Medicare levels were to go into effect, it would wipe out the $1.8 billion secured for 2025 and beyond.

The Energy and Commerce Committee was considering restrictions on other types of supplemental payments, notably provider taxes and MCO taxes (taxes on primarily private hospitals and MCOs), which are used to finance the non-federal share of Medicaid spending. Medicaid relied to a great degree on these types of supplemental payments, and any cuts or limitations to supplemental payments would be detrimental to private hospitals, clinics, and the Medicaid system in general. It was important to note that UC Health and the public hospitals participated in the provider fee to a very small degree. If allowed, the MCO tax would provide new dollars, but if not, UC would lose the potential for new dollars.

One provision that moderate and conservative Republicans seemed to agree on was the implementation of work requirements for Medicaid beneficiaries, despite evidence indicating that most Medicaid beneficiaries were already working and the fact that such requirements in some states have resulted in bureaucratic barriers to maintaining coverage. Similarly, the markup included proposals which that would make it harder to be enrolled, whether through costs or eligibility processes. The proponents of these proposals assumed that they would produce savings because enrollment would be reduced.

The Energy and Commerce Committee was also considering a proposal to repeal Biden era nursing home staffing ratios, a ban on Medicaid payments for gender-affirming care, and ending federal payments to Planned Parenthood. There was a proposal to reduce the FMAP by ten percent for states that provide insurance coverage for the undocumented population. Such a reduction would be significant for California, although many observers believed that this proposal would not pass U.S. Senate procedural rules or would be challenged by State attorneys general.

Ms. Murray reported that conservative members of the Freedom Caucus were disappointed by the list of proposals being considered today. They believed that this was a missed opportunity to roll back many provisions of the Affordable Care Act and wanted to cut Medicaid even more. Some but not many Senate Republicans, including Joshua Hawley of Missouri, were opposing these ideas.

Ms. Murray described this effort as largely an exercise in semantics. Legislators were trying to label what were in fact significant cuts to Medicaid as an effort to prevent waste, fraud, and abuse, as meaningful reforms, or as efforts to return to, support, and strengthen Medicaid, but what they meant by this was supporting the original Medicaid population before the Affordable Care Act. One had to be careful about names and labels being used, when in fact a cut is a cut.

There were some potential mitigating factors. Polls showed that Medicaid is popular and that efforts to significantly reduce coverage could jeopardize the Republicans' chances of retaining a majority in the House of Representatives in 2026. There was a cadre of moderate and vulnerable House Republicans who were influential and formed a crucial voting bloc, given the Republicans' narrow majority in the House. It was also important to remember that these savings were calculated on a ten-year basis, allowing savings to accrue starting on the effective date of the proposal. According to the current markup, the work

requirements mentioned earlier would not take effect until 2029, although the effective date could be made sooner to increase savings. The lengthy implementation period might give CAPH, UC Health, and others time to work with a new Congress or potentially a new presidential administration to reverse some of these potentially damaging policies.

Ms. Ma stated that the University would continue advocating on behalf of UC Health and the State Medicaid program in Washington, D.C. and in Sacramento, educating State lawmakers about the potential impacts of the proposed cuts. The UC Office of Federal Governmental Relations has asked the California members of the House Energy and Commerce Committee to oppose these cuts due to the large number of people who would lose coverage if these cuts were made, with a national estimate of over eight million people. UC representatives regularly meet with members of Congress to inform them that even if there is not a UC medical center in their district, UC Health is caring for their patients. She reiterated that UC Health serves patients from 91 percent of California zip codes and presented a chart with numbers of Medicaid patients and UC Health patients in the nine Republican-led California congressional districts. UC representatives were ensuring that the Republicans in California's congressional delegation understand that UC medical centers work in partnership with the community hospitals in their districts to provide care to patients, coordinate care, and accept transfers and that if these cuts were to materialize, it would be difficult for patients to receive the care they need and for providers, especially community hospitals and UC medical centers, to be able to maintain the same levels of service and staffing and to make the investments needed to care for the population across the state.

Regent Matosantos suggested that there be continued discussion about how UC Health was managing all its recent acquisitions and the associated risks. UC Health was expanding its footprint in the Medi-Cal program, doing the right thing for California, and taking on greater risk due to federal government actions. UC must be attentive to managed care rates, which must be authorized on an annual basis, supplemental payments, and potential federal actions. Ms. Murray responded that both Republican-led and Democrat-led states relied heavily on supplemental payments. For this reason, there has been significant political opposition to all the proposed limitations, especially by large Republican-led states whose Medicaid programs would almost cease to exist because of the low amount of State investment. At this time, there were advocates for Medicaid in more conservative states.

Regent Matosantos stated her understanding that because of per capita personal income in California, the state was receiving a generally lower level of funding from the federal government than states such as Alabama and Louisiana, which received a higher FMAP. Ms. Murray confirmed that this was the case. The original FMAP for California was 50 percent; even when blended with the Medi-Cal expansion population, the FMAP percentage was in the low 60s, while in other states like Louisiana, the percentage was in the 70s or 80s.

Regent Park asked about projected increases in uncompensated care and the financial impact on UC Health, assuming that specific proposals regarding work and eligibility requirements would be enacted and patients would lose insurance coverage. Chief Strategy

Officer Santiago Muñoz responded that hospitals were at full capacity. The proposed reductions and an increase in the number of uninsured was bad for California, consumers, and communities. He observed that this might not necessarily translate into higher uncompensated care because UC Health was already at capacity. UC Health needed to ensure the highest levels of access possible. Demand was so high that other patients would backfill the cost of uncompensated care.

Regent Leib asked about the status of mental health funding. Ms. Murray responded that mental health funding in Medi-Cal would also depend on the FMAP. A final package that maintains the FMAP for both the original Medicaid population and the expansion population would be a very positive outcome. California Proposition 1 awards have been released, and one county would be able to build an inpatient psychiatric hospital. There was progress in the mental health funding at the State level. How these developments would interplay with federal actions over the course of the budget reconciliation process remained to be seen.

Regent Matosantos referred to Regent Park's earlier question. She stated her understanding that if UC Health has more patients who are uninsured, but all other factors remain level, UC would have fewer capitated payments on the front end, but when patients come for episodic care later, even if they are uninsured, provided that supplemental payments are received, UC Health dollars would remain the same. This meant that it was even more important for UC Health to consider both the issue of people retaining coverage and UC Health's ability to maximize and draw as much money as possible to cover costs. Mr. Muñoz confirmed that this was the case. He noted that there is a chilling effect in the community when people become uninsured, and they forgo care. UC Health was considering the long-term implications of this. Patients show up in worse conditions, and cost increases. Dr. Rubin emphasized that the proposed federal government cuts, a ten percent reduction in the Medicaid program's size, would be detrimental to beneficiaries. While UC Health and other health systems like it could absorb this, UC Health had an obligation to partner with the State and find other solutions for points of access to address risk in episodic care. UC would have to work with FQHC partners and the State Medicaid program. He believed that FQHCs would play an important role in the discussion.

Regent Matosantos projected that, with an increase in uninsured patients, UC Health and other CAPH hospitals would likely see more patients in worse conditions further on in the process. This meant that supplemental payments, the 340B Drug Pricing Program, and other mechanisms in place to address uncompensated care must remain whole. In order to prepare for this situation, UC Health must create additional capacity and maintain as many supplemental payments as possible as well as ways of being able to maximize dollars.

UC San Diego Health Chief Executive Officer Patricia Maysent commented that one fact that resonated with lawmakers in Washington, D.C. during her recent visit was that UCSD Health worked with rural hospitals. There were two hospitals in the San Diego area and two hospitals in the Imperial Valley which were barely surviving, with a small number of days' cash on hand. The proposed Medicaid reductions would put these hospitals into bankruptcy. UCSD Health had high patient volume and needed these hospitals to stay open

and continue functioning. The situation of rural hospitals at risk was an important argument and should be highlighted.

Referring to Regent Matosantos' remarks, Ms. Murray observed that the purpose of Medicaid DSH funding was to address uncompensated care. This was the reason for advocacy to ensure that DSH funding is not cut. UC Health and other CAPH hospitals might need DSH funding more than ever.

The meeting adjourned at 4:20 p.m.

Attest:

Secretary and Chief of Staff