The Regents of the University of California

HEALTH SERVICES COMMITTEE
July 15, 2025

The Health Services Committee met on the above date at the UCLA Luskin Conference Center, Los Angeles campus.

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

In attendance: Regents Anguiano, Brooks, Hernandez, and Komoto, Regents-designate Tokita, Faculty Representative Palazoglu, Staff Advisors Frías and Hanson, Secretary and Chief of Staff Lyall, Deputy General Counsel Stayn, Chief Compliance and Audit Officer Bustamante, Executive Vice President and Chief Operating Officer Nava, Vice President Lloyd, Chancellor Muñoz, 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 May 13, 2025 were approved, Regents Chu, Leib, Makarechian, Matosantos, Park, Reilly, and Sures voting "aye."[1]

Executive Vice President Rubin prefaced the meeting by speaking of a recent loss to the University, the passing of Atul Butte, M.D., Ph.D. (1969–2025), following a long battle against cancer. Dr. Butte was a visionary in his work on the development of the Center for Data-driven Insights and Innovation (CDI2) and the team that he cultivated. Dr. Rubin emphasized Dr. Butte's forward-looking vision, humanism, smile, and his ability to inspire people to share ideas. Dr. Butte embodied the spirit of the University of California, expressed in this statement of his: "Nowhere in the else in the United States do six large academic health centers share data in a manner like we do in the University of California. Like many universities, we have multiple strengths and figuring out how to pull together and channel resources for the common good is a challenge. When it works, it's incredible and I do believe nothing can stop us." Dr. Butte was irreplaceable, and UC Health would carry on his legacy with gratitude.

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

2. **APPROVAL OF ADMINISTRATIVE STIPEND FOR MADELYN (MADDY) PEARSON, CHIEF NURSING EXECUTIVE AND VICE PRESIDENT OF PATIENT CARE SERVICES, UCSF HEALTH, SAN FRANCISCO CAMPUS AS DISCUSSED IN CLOSED SESSION**

The President of the University recommended that the Health Services Committee approve the following items in connection with an administrative stipend for Madelyn (Maddy) Pearson, Chief Nursing Executive and Vice President of Patient Care Services, UCSF Health, San Francisco campus, in addition to her current base salary of $668,766:

A. An administrative stipend of 7.5 percent ($50,157 annualized) of Ms. Pearson's current base salary ($668,766), effective July 1, 2025, through June 30, 2026, or until a new Chief Nursing Officer – Adult Services (CNO-AS) is hired, whichever occurs first.

B. Per policy, continued eligibility to participate in the Clinical Enterprise Management Recognition Plan's (CEMRP) Short Term Incentive (STI) component, with a target award of 15 percent ($107,838) of base salary plus the portion of the annualized administrative stipend received during each plan year and maximum potential award of 25 percent ($179,731) of base salary plus the portion of the annualized administrative stipend received during each plan year, subject to all applicable plan requirements and Administrative Oversight Committee approval. Any actual award will be determined based on performance against pre-established objectives.

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

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

E. For any outside professional activities, Ms. Pearson will 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, the President, or the Chancellor, 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.]

Vice President Lloyd introduced the item, which recommended approval for an administrative stipend for Madelyn (Maddy) Pearson, Chief Nursing Executive and Vice President of Patient Care Services, UCSF Health, San Francisco campus for temporary assumption of significant additional responsibilities. The proposed stipend was $50,157, 7.5 percent of her current base salary. Because the current base salary plus the stipend placed this compensation at the 83rd percentile of the Market Reference Zone for her position, this action required Regents' approval.

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

3. **APPROVAL OF APPOINTMENT OF AND COMPENSATION FOR WENDY HORTON AS SENIOR VICE PRESIDENT AND PRESIDENT – ADULT SERVICES, UCSF HEALTH, SAN FRANCISCO CAMPUS 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 Wendy Horton as Senior Vice President and President – Adult Services, UCSF Health, San Francisco campus:

A. Per policy, appointment of Wendy Horton as Senior Vice President and President – Adult Services, UCSF Health, San Francisco Campus, at 100 percent time.

B. Per policy, an annual base salary of $1.05 million.

C. Per policy, a hiring bonus of 20 percent ($210,000) of base salary, which is intended to make the hiring offer market-competitive and assist in securing Ms. Horton's acceptance of the offer. The hiring bonus will be paid in a lump sum subject to the following repayment schedule if Ms. Horton separates from the University or accepts an appointment at another University of California location within two years of her appointment: 100 percent if separation occurs within the first year of employment, and 50 percent if separation occurs within the second year of employment, subject to the limitations under Regents Policy 7705, Senior Management Group Hiring Bonus.

D. Per policy, eligibility to participate in the Clinical Enterprise Management Recognition Plan's (CEMRP) Short Term Incentive (STI) component, with a target award of 15 percent of base salary ($157,500) and maximum potential award of 25 percent of base salary ($262,500), subject to all applicable plan requirements and Administrative Oversight Committee approval. Any actual award will be determined based on performance against pre-established objectives and may be prorated in Ms. Horton's first year of participation based on her hire date. If her hire date is on or before January 1, 2026, she will be eligible to participate in the STI component of CEMRP starting in the 2025–26 plan year, which started on July

1, 2025 and ends on June 30, 2026. If her start date is after January 1, 2026, she will be eligible to participate in the STI component of CEMRP beginning in the 2026-27 plan year, which starts on July 1, 2026 and ends on June 30, 2027. Ms. Horton's first possible short-term incentive award will be determined following the close of the plan year for which she is first eligible to participate.

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

F. Per policy, reimbursement of actual and reasonable moving and relocation expenses associated with relocating Ms. Horton's primary residence, subject to the limitations under Regents Policy 7710, Senior Management Group Moving Reimbursement. If Ms. Horton voluntarily separates from this position prior to completing one year of service or accepts an appointment at another University of California location within 12 months of her initial date of appointment, she will be required to pay back 100 percent of these moving and relocation expenses.

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

H. For any outside professional activities, Ms. Horton will comply with the Senior Management Group Outside Professional Activities (OPA) policy and reporting requirements.

I. This action will be effective as of Ms. Horton's hire date, estimated to be no earlier than September 1, 2025

The compensation described above shall constitute the University's total commitment until modified by the Regents, the President, or the Chancellor, 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.]

Vice President Lloyd explained that the previous incumbent in this role at UCSF stepped down as of November 28, 2024. The campus has completed an open and competitive recruitment resulting in the selection of Wendy Horton as Senior Vice President and President – Adult Services, UCSF Health. The base salary of $1.05 million was above the 90th percentile of the position's Market Reference Zone, as this candidate pool can be very scarce and the market was competitive for academic leaders with the appropriate background to lead a large and complex academic health system. In addition, the San

Francisco campus was seeking approval for a hiring bonus of 20 percent of the proposed salary ($210,000), which was intended to ensure that the offer is market-competitive and secures acceptance of the offer. Because the proposed base salary exceeded the 90th percentile, approval by the Regents was required.

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

4. **ESTABLISHMENT OF A NEW LEVEL TWO SENIOR MANAGEMENT GROUP POSITION OF ASSOCIATE VICE PRESIDENT – STRATEGIC PARTNERSHIPS, UC HEALTH, OFFICE OF THE PRESIDENT, AND THE MARKET REFERENCE ZONE FOR THE POSITION**

The President of the University recommended that the Health Services Committee approve:

A. Establishment of a new Senior Management Group position of Associate Vice President – Strategic Partnerships, UC Health, Office of the President. This will be a Level Two position in the Senior Management Group.

B. Establishment of a Market Reference Zone for this position as follows: 25th percentile – $458,300, 50th percentile – $531,400, 60th percentile – $559,800, 75th percentile – $602,500, and 90th percentile – $652,500.

C. This action will be effective upon approval by both the Health Services Committee and the Governance 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.]

Vice President Lloyd introduced the item, which sought approval for establishment of a new Level Two Senior Management Group position for UC Health and a corresponding Market Reference Zone (MRZ) for the position. Regents' approval was required for the establishment of the new position and MRZ.

Executive Vice President Rubin outlined the rationale for this position. UC Health has been reviewing its strategic framework, and some key elements of this framework were engagement with the State and federal government and developing the UC Health network in alignment with the needs of the State of California. Given the size of UC Health, it needed a skilled negotiator to lead UC Health partnerships with the State and federal government as well as relationships with Medi-Cal plans throughout California. This position would add value, as opposed to using consultants, and would be part of a new Office of Strategic Partnerships within UC Health.

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

5. **UC MEDICAL CENTER PHARMACY AT THE CROSSROADS OF INNOVATION AND RISING COST**

[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 the discussion, noting that the growing cost of pharmaceuticals was a major issue affecting the work of all healthcare professionals. The issue was more complex for the UC medical centers and medical schools because these were places where new treatments were being engineered, such as cell and gene therapies, which would change the delivery of care in the future.

UC Davis Health Chief Pharmacy Officer Chad Hatfield reported that pharmacy costs were rising at about ten percent annually on average. This was one of the fastest-growing expenses at UC Health. The primary cost drivers were innovative therapies, outpatient therapies, and growth in pharmacy services in the ambulatory care setting. In trying to curb this cost trend, UC must consider the inpatient and outpatient settings. There were opportunities for UC to advocate for relevant policy revisions and opportunities in pharmacy benefit management.

UC Health serves nearly two million unique patients each year, providing over nine million outpatient visits. Approximately 72 percent of UC Health inpatients are covered by Medi-Cal or Medicare. UC Health delivers about $5 billion annually in community benefit and uncompensated care for underserved populations. Dr. Hatfield presented an example of patients treated at UCLA, 14-year-old twins with rare disease, Duchenne muscular dystrophy, which causes severe muscle weakness. The twins were treated with Elevidys, a curative gene therapy, and ultimately were able to ambulate and participate in school. This was an example of a new wave of gene and cellular therapies.

UC Health's total operating expenditures across all medical centers have reached $21 billion. Pharmacy spending alone accounted for $2.6 billion, making it the second-largest expenditure category. The causes included inflation, drug shortages, and far costlier curative therapies. Dr. Hatfield presented a chart showing UC pharmacy expenditure growth from 2021 to 2025, with a consistent year-over-year increase in total pharmacy expenditures. He attributed the particularly large percentage change of 26 percent in 2025 to the acquisition of new hospitals and the growth of the portfolio, but most of the increase over time was due to price inflation and expansion of ambulatory care. About two-thirds of UC pharmacy expenditures were in ambulatory, outpatient care settings. The outpatient costs were reimbursable by UC's payers. Only one-third of pharmacy expenditures were in the inpatient setting. UC Health's inpatient capacity was limited, and many patients and therapies were migrating to ambulatory care. Federal and State healthcare policies were putting pressure on the University, as was consumer demand. The patient population was

growing older as well, and UC Health was using more medications across the continuum of care.

UC Health Chief Pharmacy Officer Cedric Terrell noted that each state in the U.S. was seeking to curb healthcare expenditures. In California, the Office of Health Care Affordability (OHCA) has put in place a growth target over the next five years, with the intention of reducing the overall cost of healthcare expenditures. UC Health must be mindful of market trends and meet consumer demands. While UC Health was held accountable for the quality outcomes, especially with respect to innovative therapies, it was competing against commercial entities such as CVS, Walgreens, and Amazon. To respond to consumer demand, UC must remain innovative and maintain continuity of care for its patients. UC must have discussions with the State about how new policies would affect UC's ability to provide novel therapies and quaternary care. OHCA's growth targets were phased: 3.5 percent in 2025–26, 3.2 percent in 2027–28, and three percent beginning in 2029. OHCA was open to consultation and has communicated with the University. UC has expressed its concern that OHCA should consider the impact of high-cost curative treatments in its enforcement of cost growth targets.

UC Health used a number of strategies to mitigate drug expenditures, including formulary management, and worked collectively as a system to mitigate shared problems. The importance of the 340B Drug Pricing Program had been discussed at the May meeting.

Dr. Terrell briefly outlined how Pharmacy Benefit Managers (PBMs) function. Drug manufacturers produce medications and work with PBMs, who act as intermediaries. PBMs negotiate with health plans, contract with pharmacies, and set reimbursement rates. There was a lack of transparency in the rates that PBMs negotiate with manufacturers, health plans, and pharmacies. It was in this space that UC Health could seek to reduce its costs, working with its own health plans and providing services for which it currently contracted with PBMs. UC Health had three key future strategies in this area. The first was advocacy concerning drug affordability, maintaining the 340B Drug Pricing Program, and OHCA cost targets and high-cost novel therapies. The second was to continue to leverage the collective expertise across UC Health, and the third was to evaluate PBM opportunities.

UCLA Health President Johnese Spisso raised three points. She observed that UC pharmacy costs have risen because the system has grown larger and has increased access. At UCLA, the oncology drug budget alone, just in its 20 outpatient oncology centers, was about $250 million. Second, UC Health sites were among the very few in the U.S. with advanced cellular therapies. UCLA was delivering more than 12 gene therapies, one-time costly curative agents to treat conditions such as spinal atrophy and hemophilia. By providing these therapies, UC was reducing the number of expensive hospitalizations. In UC's initial discussions with OHCA, the focus was on the total cost of care rather than just on pharmaceuticals. Third, there were continued opportunities for UC Health to work together as a system on the 340B Program. It was appropriate at this time to reflect on the tremendous value of research. Research at the UCLA School of Medicine benefits UCLA patients. This made UCLA Health unique, and patients came from around the U.S. and the world for unique gene therapies.

Committee Chair Sures asked if UC was leveraging all its medical centers together in negotiation for drug costs in the 340B Program, or if this was negotiated campus by campus. Dr. Rubin emphasized that there was a high degree of collaboration across UC in pharmacy pricing. Dr. Terrell responded that UC negotiated a master agreement for the UC Health sites.

Committee Chair Sures asked if UC worked with only one PBM. Dr. Terrell responded that the PBM worked with health plans. Each UC health plan had its own PBM.

Regent Komoto observed that rising inpatient pharmacy costs caused problems because they were capped as a bundle payment but requested clarification regarding problems with outpatient pharmacy reimbursement. He knew institutions providing chemotherapy drugs which had access to the 340B Program and were well reimbursed. Dr. Hatfield responded that this presentation wished to make clear that there were large expenditures for ambulatory care. This did not mean that these were not worthwhile expenditures. Certain therapies with the same outcomes might be better reimbursed. Ms. Spisso added that UCLA was receiving appropriate reimbursement for outpatient pharmacy costs and through the 340B Program. UCLA had worked with private and governmental payers to ensure coverage for new emergent therapies. UC San Diego Health Chief Executive Officer Patricia Maysent commented that outpatient pharmacy reimbursement was an important margin generator for UCSD which helped cover other shortfalls.

Regent Komoto referred to the PBM opportunity and asked if UC could participate in the State program, which was well designed and provided significant rebates. Dr. Terrell responded that UC has identified opportunities which remained to be explored. The University was working with the State on renegotiating contracts for limited distribution drugs. The manufacturers of these drugs currently only distributed them through CVS and Walgreens.

Advisory member Good encouraged the University to actively pursue the PBM opportunity. He reported that his institution, the University of Utah, reviewed the health benefit it provided and carried out a careful analysis of five years of claims. Thirty-three percent of the growth in expenditures was due to the growing employee base, 20 percent for outpatient care, but 40 percent of spending was for pharmaceuticals. Pharmaceutical spending was 20 percent for traditional medications and 20 percent for new medications such as Skyrizi, Dupixent, and Ozempic. One of the University of Utah's initiatives regarding pharmacy spending was to create its own transparent PBM. In its first year, the PBM returned a rebate of about $3 million or eight percent on pharmacy spending of $35 million. Earlier, this return flowed into a non-transparent process and probably became corporate profit. A PBM driven by the UC system should bring about significant pharmaceutical savings.

Committee Chair Sures asked what would be needed to establish a PBM at the University of California. Dr. Terrell responded that UC Health Director of Strategic Pharmacy Projects and Partnerships Brian Davis worked in this area and could provide information on resource needs at a future meeting. UC has been providing consultation to its health

plan leaders on therapies and rebates. While UC has been able to maximize rebates, Dr. Terrell believed that the University was leaving money on the table by using a middleman rather than managing pharmacy benefits itself.

Committee Chair Sures asked if this topic could be presented in the next few meetings. Dr. Terrell responded in the affirmative. UCLA Health Associate Chief of Ambulatory Pharmacy Ghada Ashkar added, with respect to PBMs, that UC had patients and even employees for whom it could not provide drugs due to PBM lockouts. PBMs require prescriptions to be filled at pharmacies they are affiliated with. This lockout amounted to as much as 40 percent of the medications that UC could be providing.

Regent Park stressed that the University must proceed beyond discussions of strategy in this area. UC had been lagging on executing on a strategy. She asked about OHCA, and if UC was trying to have an impact on a regulatory process. Associate Vice President Tam Ma explained that OHCA was a relatively new State regulatory body, housed in the Department of Health Care Access and Information, which sought to control the growth in healthcare spending in California and has set a cost growth target for healthcare entities including health plans and providers such as UC Health. As mentioned earlier, OHCA had set a target of 3.5 percent for 2025–26, and the target would decrease to three percent beginning in 2029. This effort was in the beginning stages, and much work remained to be done to determine how cost growth targets would be enforced.

Regent Park asked if OHCA has already established these targets through rulemaking and if there was a public comment period. Ms. Ma responded in the affirmative. Regent Park asked about the state of negotiations. Ms. Ma responded that OHCA has not yet determined how it would enforce the targets and what the reasonable factors would be that would cause an entity to exceed cost growth targets. There were underlying costs over which healthcare providers might or might not have control. In its advocacy, UC was stressing that, when UC exceeds its target, OHCA should take into account factors such as the growth in cost of supplies including pharmaceuticals, over which UC had no control.

Regent Park asked if this was the second round of rulemaking. Ms. Ma responded that OHCA would eventually proceed to formal rulemaking; discussions about this were now ongoing.

Regent Park requested a separate briefing on OHCA. Ms. Ma stated that she would provide this.

Regent Matosantos requested clarification about the PBM opportunity, noting that there was already an established program for Medi-Cal patient pharmaceuticals. The University might seek to work with the California Department of General Services, but there was a question of which drugs the Department was purchasing and if this would be advantageous for UC. She asked how the University would achieve better rates for patients, given the various actors and patient populations involved. UCSF Health Chief Executive Officer Suresh Gunasekaran responded that UC could begin by managing these benefits for its own employees and health plans. An integrated strategy at UC would have to align three

components: a health insurance partner, a PBM partner or structure, and UC physicians and medical centers as a partner. The alignment of these three components would be of tremendous benefit to UC employees. UC physicians' expertise would determine which formularies would have the maximum benefit and impact. Costs could also be aligned. Although there were existing PBM structures that UC could attach itself to, this might not be easy. Even if UC were attached to a PBM for certain pricing, it might not agree on the formulary. Rebates and discounts were with specific manufacturers on specific components of the formulary. There was a general understanding of the problem, but multiple parties were involved in unraveling it. UC Health was interested in this opportunity because UC employees and patients could benefit from it. The first step for UC would likely be to manage this benefit for its own employees, and the second step would be for government health plans such as Medi-Cal and Medicare Advantage. There was one such plan managed by UCLA. It was for these populations that this opportunity would have the first tangible impact. Mr. Gunasekaran emphasized that this would require a large amount of work and a new level of expertise. Ms. Spisso remarked that UCLA was considering establishing a PBM for its Medicare Advantage plan. UC Health had elements of this infrastructure in plan form. PBMs were a focus of attention nationwide by various parties because they were a source of profit.

Regent Matosantos stated her understanding of the proposed process. UC had the greatest ability to provide benefits first for its employee population. In doing this, it would establish the infrastructure, direct purchasing, and formulary. At that point, UC would evaluate whether it made sense to expand this to other patient populations and how this might fit into negotiations with commercial health plans.

Committee Chair Sures asked if an outside consultant could assist the University, or if this must be done internally. Mr. Gunasekaran responded that the first step would be figuring out the health plan strategy for UC employees; this would be the foundation upon which the PBM plan would be built. UC could engage advisors and consultants, who would likely ask about the target population. The UC system offers multiple health benefits and would have to determine where to begin the PBM process. It would initially not be all for employees, but a portion of UC employees with a specific benefit designed in conjunction with the PBM plan.

Ms. Maysent expressed confidence in the ability of UC Health chief pharmacy officers and their clinical and business knowledge and acumen. The chief pharmacy officers were a highly collaborative group who, when given a direction, would produce outstanding results.

Advisory member Noonan underscored the effect of PBM lockouts, mentioned earlier, on customers and employees. There was also an issue of equity regarding independent pharmacies that poorer communities rely on. She reported that during the COVID-19 pandemic, three locally-owned pharmacies in Camden, New Jersey were not part of the federal pharmacy program for distribution of COVID vaccines to the community because the government only deals with the big pharmacy chains. When Ms. Noonan and her

organization realized this, they were able to have vaccines distribution to these pharmacies, and this completely changed the local COVID statistics.

Regent Park referred to the actions outlined by Mr. Gunasekaran. She believed that this has been discussed now and again for a long time. She wondered if it would be helpful to request a specific plan for the Regents' consideration. If this would be helpful, she would be happy to request such a plan. Committee Chair Sures concluded that this discussion would continue across a number of different areas of the University. There was a logical path forward that would have to be determined.

6. **MEDICAL SCHOOL CURRICULUM: ACCREDITATION REQUIREMENTS, UNIVERSITY OF CALIFORNIA ACADEMIC SENATE OVERSIGHT, AND ATTAINMENT OF COMPETENCY**

[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 the discussion, which would focus on the intersection between the accreditation required for UC medical schools and the amount of quality control involved in implementing the curriculum.

Associate Vice President Deena McRae explained that to deliver the best possible care to communities and to uphold the high academic standards of the University, there must be reliable processes to ensure that UC medical students are exposed to the necessary curriculum and experiences in order to attain and demonstrate competency. There were many policies and procedures in place to continuously monitor and assess the curriculum with effective quality improvement processes to ensure that the UC medical schools continue to be top-ranked medical schools in the nation.

Michelle Daniel, Vice Dean for Medical Education at the UC San Diego School of Medicine, discussed the accreditation of UC medical schools by the Liaison Committee on Medical Education (LCME). The LCME accredited all M.D.-granting medical schools in the United States. The system was rigorous and consisted of 12 overarching standards and 93 individual elements, each representing a specific area critical to ensuring quality in medical education. Schools must submit extensive documentation to demonstrate compliance with the intent, not just the letter, of each standard and this included evidence from in the form of bylaws, committee charges, minutes from committee meetings, policies, and actual practices. Accreditation visits occurred every eight years with annual monitoring in between. A central theme of LCME accreditation was governance, specifically that authority over core medical school functions must reside within the School of Medicine, not within campus or system-level entities that might lack educational expertise in medicine. This is underscored by LCME standards and elements. According to Element 1.3, school of medicine faculty must meaningfully participate in governance, including on committees and in policy decisions. Per Element 1.5, school of medicine bylaws must clearly define the authority of the dean, faculty, and educational committees. The dean must have final authority over the medical education program and its resources.

The school of medicine is responsible for its own policies, and campus bodies like the Academic Senate may advise but not give direction. According to Element 8.1, authority over curriculum content, pedagogy, and evaluation must rest within a school of medicine committee, not external bodies. Standards for grading and promotion must be set and enforced by school of medicine-specific committees. Student advancement and graduation decisions must be made by those with in-depth knowledge of the curriculum and its learners. Admissions decisions must be made by the school of medicine's recruitment and admissions committee. These elements were non-negotiable accreditation expectations, ensuring that educational authority remains where the expertise is, in the school of medicine.

In addition to governance, the LCME had a number of standards that dictated the content of the medical curriculum, and these spanned areas ranging from the biomedical sciences to scientific method, critical judgment, societal problems, structural competence, cultural competence, and health inequities. Two LCME elements that might encounter some challenges with current federal executive orders, depending on how schools decided to implement them, were Element 7.5 regarding societal problems and Element 7.6 pertaining to cultural competence and health inequities. Schools have flexibility in determining the precise content they decide to cover in their curriculum.

LCME accreditation was complex and exacting, with dozens of interlocking elements that depended on strong internal governance. There were many layers of oversight, but for LCME compliance, the locus of control must reside in the school of medicine through its faculty and committees. Structures in which final decision-making authority resided outside the school of medicine, such as with a campus Academic Senate, were not viewed favorably by the LCME, especially if those bodies can be perceived as overriding school of medicine decisions without content expertise. At UC San Diego, the Academic Senate has delegated authority to the School of Medicine committees, in alignment with LCME expectations. Dr. Daniel concluded that it was critical that the University preserve and protect this structure in the future as UC thoughtfully responds to concerns about academic oversight.

Advisory member Ong, Professor in Residence in the Department of Medicine at the UCLA School of Medicine, discussed the role of the UC Academic Senate in the curriculum of UC medical schools. The Regents' Bylaws that establish the Academic Senate state that, subject to the approval of the Regents, the Academic Senate determines the condition for admission and conferral of degrees. The Senate also authorizes and supervises all courses and curricula, except in specific instances. For the purposes of this discussion, medical schools fall under the exemption for professional schools offering work at the graduate level only. The Senate also cannot make changes in the curriculum of the college or professional school until said change has undergone formal consideration by the faculty concerned.

The Academic Senate, through its Coordinating Committee on Graduate Affairs (CCGA), has purview over graduate education. Thirty years ago, it was determined that CCGA delegated Senate oversight responsibilities regarding graduate education to the

professional schools. UC medical schools were exempt from direct Academic Senate supervision because the Academic Senate has re-delegated its authority on admissions and degrees and because of the Regents' Bylaw provision for medical schools to retain authority on courses and curriculum.

As an example, the UCLA Academic Senate and its Academic Program Review Committee oversees courses and curricula at UCLA's College of Letters and Science but not at the School of Medicine. Instead, the School of Medicine has a parallel Faculty Executive Committee, which has six subcommittees, one of which is the Medical Education Committee, which oversees courses and curricula at the School of Medicine.

UCLA School of Medicine Dean Steven Dubinett stated that the School considered accreditation to be not just a benchmark but a comprehensive and continuous process that safeguards the quality of the academic program and ensures that the School is preparing students to meet the evolving needs of health care. The School upholds LCME Element 8.1 by maintaining a rigorous and transparent governance structure. The Faculty Executive Committee, which is an elective body representing the entire medical school faculty, holds ultimate responsibility for the design, conduct, and approval of the curriculum together with the Dean. The Faculty Executive Committee delegates curriculum oversight to the Medical Education Committee, which is charged with the continuous review, integration, and improvement of the UCLA M.D. program. The Medical Education Committee conducts in-depth, data-driven reviews of each phase of the curriculum through the "state of the curriculum" process, which covers four key areas: pre-clerkship, clerkship, discovery, and electives. Faculty, students, and staff are invited to participate and provide input at every stage.

Regarding best practices, the School of Medicine has established several processes that strengthen its accreditation standing and foster continuous quality improvement. These involve collaborative oversight. The Faculty Executive Committee and the Medical Education Committee function in close partnership, ensuring that any proposed curriculum redesign is thoughtfully developed, thoroughly vetted, and endorsed by the faculty before being submitted to the LCME for review and approval. There is also work by a number of subcommittees under the Medical Education Committee, including pre-clerkship and clerkship chairs committees and the M.D. Continuous Quality Improvement Committee. They monitor every component of the curriculum. These groups routinely analyze assessed data, course evaluations, and learning outcomes to identify areas for refinement. UCLA also has an LCME-aligned quality improvement process. The committee charged with this work evaluates the program specifically through the lens of the LCME standards, proactively identifying gaps and ensuring that the School of Medicine remains fully compliant with evolving accreditation requirements.

This work involves transparency and faculty engagement. All Faculty Executive Committee and Medical Education Committee meetings are open to faculty attendees, which reinforces transparency, encourages engagement, and fosters a culture of shared responsibility for the School's educational mission. Despite these strengths, maintaining accreditation was not without challenges. The modern medical curriculum was

increasingly interdisciplinary and longitudinal. Designing and managing such a curriculum in a coordinated and coherent fashion was essential and required by the LCME. This demanded consistent alignment across many stakeholders and departments and included data integration. Effective curriculum evaluation required timely, accurate data collection and integration from numerous sources, including student assessments, faculty feedback, and clinical outcomes. Ensuring the consistency and utility of these data remained a challenge.

Redesigning curriculum in response to emerging science, student needs, or LCME expectations required thoughtful change management. Evidence-based improvements can encounter resistance if faculty and trainees are not adequately prepared and supported through the transition. Finally, the LCME periodically revises its expectations to reflect advances in medical education. Staying ahead of these shifts while maintaining high standards in teaching and clinical care required adaptive leadership and robust internal review processes. The approach at the UCLA School of Medicine was focused on transparency, shared governance, continuous quality improvement, and faculty-driven innovation. Dr. Dubinett expressed appreciation for the Regents' support as UCLA meets these challenges and upholds its mission to train the next generation of caring and confident physicians.

Dr. McRae concluded the presentation by stating that UC medical schools work hard to find the right balance between maintaining compliance with LCME accreditation standards, ensuring that medical students attain competency in all key areas, and at the same time creating space for faculty to have some autonomy and creativity in teaching, because UC Health wishes to foster an environment of innovation. Only through trying new teaching models and curricula can the University remain a leader in education and find ways to improve and share knowledge more effectively. UC medical education must be nimble and respond to the constantly changing landscape and must take into account different styles of learning, which can require flexibility and creativity. The ability to develop new teaching approaches and content was critical to maintain the University's international reputation for excellence in teaching.

Regent Brooks asked if there were elements in the curriculum that enhance cultural sensitivity and instill an appropriate sense of humility and compassion when dealing with cultural differences. Dr. McRae responded that the medical schools strove to provide instruction and experiences to ensure that medical students have effective communication with their patients. Trust between the patient and the doctor leads to improved health outcomes. UC Health wished to ensure that students and residents were trained to provide culturally competent and sensitive care. UC Riverside School of Medicine Dean Deborah Deas added that her School had a curriculum thread focused on health equity and social justice, in which all students were engaged. Students could not opt out of this thread. Students also participated in community-based learning, working with community stakeholders in the health field, community clinicians and patients.

Regent Anguiano asked about the role of artificial intelligence (AI) in the medical school curriculum. She noted that there was an AI company that worked on detecting breast

cancer. Dr. Dubinett responded that UCLA Health was addressing AI and its use in a number of areas. UCLA had a Department of Computational Medicine, and UCLA was in the final stages of a search for an AI leader who would work closely with UCLA Health. Imaging can serve as a front door for diagnosis and risk assessment. UC Health was working to use imaging as part of predictive medicine, taking advantage of the UC Health Data Warehouse. UC wished its students to be engaged at every level, in research, learning, and the application of the process.

Regent Chu asked about using AI and new technologies in health administration. Dr. Rubin responded that all UC Health locations were interested in the adoption of new technologies in areas such as radiology, population health, patient care away from the office, and everyday tasks such as pharmacy refills. The adaptation of AI in healthcare training and delivery was a topic on its own and could be discussed at a future meeting with subject matter experts. Regent Chu stated that such a discussion would be beneficial.

7. **UC HEALTH POLICY UPDATE**

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

Executive Vice President Rubin noted that the federal budget reconciliation process had now ended. This discussion would focus on outcomes and impact on UC Health.

Associate Vice President Tam Ma began the discussion by recalling the importance of Medi-Cal as a source of revenue for UC's academic health centers. Over one-third of inpatient days were provided to Medi-Cal patients. Medi-Cal made up 20 percent of UC Health's net patient revenue. The federal government paid for a large portion of the Medi-Cal budget, two-thirds of the $175 billion program. Federal funding cuts or other policy changes can have a tremendous impact on the University's Medi-Cal program.

Kent Springfield, Director of Health and Clinical Affairs in the Office of Federal Governmental Relations (FGR), stated that shortly after the U.S. presidential election in 2024, FGR and UC Health worked to increase Medicaid advocacy on several fronts. UC worked with the prior presidential administration and the State of California on approval of increases to Medicaid State-directed payments. These increases were more important than ever, given the dynamics of the final reconciliation bill. The University also communicated directly with California's nine Republican members of the U.S. House of Representatives to highlight the potential harm of Medicaid cuts. None of these nine members directly represented a UC campus, medical center, or National Laboratory. UC's advocates brought together data on systemwide impacts from UC and UC Health in those specific congressional districts. In dozens of meetings with members and staff over the first half of this year, UC representatives focused on the potential impact of Medicaid cuts on patients and how specific proposals would harm UC and California. Early in the process, UC called the California delegation's attention to a proposal, backed by conservative think tanks, which would have cut the floor of the federal matching rate for traditional Medicaid, resulting in as much as $387 billion in cuts to California and a handful of other states with

limited Republican delegations. The University was grateful to Congressman David Valadao and others in the delegation for their insistence that this cut not be included in the final bill.

President Drake, the chancellors, Dr. Rubin, the medical center chief executive officers, government relations directors, and many others have participated in UC's efforts to educate the California congressional delegation on the potential harms of Medicaid cuts, including specific proposals. The University strongly and clearly opposed the bill at each point in the process. The UC Advocacy Network ran two campaigns on the bill, engaging more than 2,800 advocates who sent nearly 5,000 emails reaching every member of the California delegation as well as members in 37 states. While the University was certainly disappointed in the outcome of this piece of legislation, UC appreciated efforts by Mr. Valadao and Congresswoman Young Kim to raise concerns about the size and scope of these Medicaid cuts, including three public letters to House leadership. The University appreciated the time and attention that many Republican House members gave to hear UC concerns, even if UC ultimately disagreed with them on the bill. The University hoped that it had left these conversations in a place where UC can continue to educate House members about the impacts of the bill in the months ahead with an eye toward finding opportunities to revisit some of the most problematic areas in the future.

Ms. Ma noted that the bill was signed into law on July 4, while a few weeks later, July 30, would mark the 60th anniversary of the Medicaid program as well as Medicare. Over these many decades, Medicaid has provided a critical lifeline to Americans and enabled access to health care. Unfortunately, this reconciliation bill made the largest reduction to Medicaid in history by cutting Medicaid spending by one trillion dollars over a decade. It was estimated that about 12 million people across the U.S. would become uninsured by 2034 as a result of provisions included in this bill. There were provisions that limited states' ability to finance Medicaid programs with a non-federal share and that increased barriers to enrollment and coverage for people who qualify for the program. A number of the provisions focused cuts and penalties on states like California, which have expanded Medicaid under the Affordable Care Act.

The University would continue to work to understand the bill and its implications for UC Health. Many details were not yet known about how the various provisions would be implemented, and UC was awaiting guidance from the federal government. Ms. Ma presented a timeline for key Medicaid provisions in the reconciliation bill based on the best information currently available. A freeze in State-directed payments and provider taxes took effect immediately when the bill was signed, as well as new provider tax rules. Other provisions would come into effect toward the end of 2026. Cuts to State-directed payments would begin in January 2028. Additional changes to the provider tax and cost sharing for the expansion population would take place closer to the end of 2028.

Ms. Ma recalled that Medicaid supplemental payments were a significant source of Medi-Cal reimbursements for UC and made up 58 percent of the total payments UC hospitals received for providing care to Medi-Cal patients. A key issue that UC was following in the process of the reconciliation bill was proposed changes to State-directed payments. Before

the bill was passed, the upper payment limit for State-directed payments was the average commercial rate, which was generally higher than the Medicare rate. The reconciliation bill has frozen existing State-directed payments at current levels and lowered the ceiling for these payments from the average commercial rate down to the Medicare rate beginning in 2028.

The University has worked with the California Association of Public Hospitals and Health Systems to bring State-directed payments closer to the average commercial rate, and this has resulted in significant increases in the direct payment programs over the last two years. For the current year, 2025, the previous federal administration approved preprints to increase these payments by 48 percent for the enhanced payment program and 70 percent for the quality improvement program. State-directed payments for UC were currently above the Medicare rate, and the reconciliation bill would reduce these payments beginning in 2028 by ten percent a year until they reach parity with Medicare. UC Health currently estimated that this would result in a cumulative reduction of approximately $100 million.

The reconciliation bill would also change the federal matching rate for emergency Medicaid services for undocumented immigrants and some lawfully present immigrants who are otherwise not eligible for federally funded Medicaid coverage. Through emergency Medicaid, federal law reimbursed hospitals for the cost of emergency care provided to these individuals. The reconciliation bill cut the federal matching rate for these emergency services from 90 percent to 50 percent. UC estimated that this action would have a $30 million impact under current federal and State law, but if there were enrollment changes among this population, the fiscal impact of this provision could grow. If people disenroll from Medicaid or Medi-Cal due to concerns about immigration enforcement or because federal or State policy changes regarding coverage for undocumented individuals, this would increase the cost impact because people without access to comprehensive care end up relying on emergency departments for care. These patients would come to UC emergency departments with worse conditions. UC Health would care for these patients but would receive lower payments for these services due to the lower federal match.

Provider taxes were another key source of Medicaid financing for states. The reconciliation bill prohibited states from establishing new provider taxes or increasing the rates of existing taxes, adding new rules for determining whether a provider tax is permissible. California had some provider taxes which did not comply with these new rules. One was the private hospital tax, which funded the non-federal share for private hospitals including UCSF Benioff Children's Hospital Oakland. Another provider tax affected by the changes was California's Managed Care Organization (MCO) tax which, through Proposition 35, supported Medi-Cal funding for provider rate increases including $150 million for designated public hospitals such as UC Health and funding for a statewide graduate medical education program administered by UC. The University was awaiting additional details about the changes to the provider tax rules.

The reconciliation bill also made changes to Medicaid eligibility and enrollment rules. The most significant change was in the form of community engagement requirements, namely, work requirements. The bill required adults to participate in qualifying activities for at least

80 hours a month. Data indicated that most Medicaid recipients do indeed work, but reporting requirements and additional paperwork would create challenges.

Regent Leib asked if it would be possible to circumvent this paperwork in California simply by verifying an individual's income and income tax paid, which would be a sufficient indication that an individual qualified for coverage. Ms. Ma responded that individual income was currently verified to determine Medicaid eligibility. The Medicaid program did not have details about individuals' monthly work hours. UC Health did not yet know what the federal government would require states to do to implement the work requirements. There might be opportunities to automate some processes, and there would be many logistical and operational challenges in trying to make the process as easy as possible for Medicaid enrollees.

Regent Leib asked when the new provider tax rules would take effect. Ms. Ma responded that these changes took effect immediately, on July 4. Technically, right now, the California MCO tax was considered not in compliance with the federal rules. The U.S. Department of Health and Human Services had the discretion to provide states with a transition period. Ms. Ma believed that the State had not yet received communication from the federal government on this matter.

Regent Leib asked about the financial impact of these changes on UC. Ms. Ma responded that the MCO tax and provider rate increases would provide $150 million for designated public hospitals including UC Health and county systems. The State had not yet determined how this funding would be divided among these entities. The State has also been working on a methodology for other rate increases, but this has not yet been finalized. The impact on the State budget, if the MCO tax were invalidated, would be at least $4 billion. Dr. Rubin added that the loss of $4 billion in revenue in the State General Fund, when California's healthcare programs were already in deficit, would have a distributive effect. The loss of the MCO tax would mean that 1.5 million to two million individuals would no longer have health insurance. The effect of the loss of supplemental payments would be even worse for public hospital systems than for UC Health. One must consider the implications of hospital closures, overcrowding in emergency departments, and patients with more severe conditions for UC Health capacity constraints.

Regent Sures commented that this problem would not be unique to California, but nationwide. He asked if other states might experience even worse effects than California. Dr. Rubin responded that the federal government's actions would affect all states, but not all Medicaid programs were the same. The fact that California has grown its Medicaid program in an outstanding way would create unique vulnerabilities which would be worse than in other states.

Regent Leib observed that the taxes in question were California taxes. Ms. Ma explained that every state has some form of provider tax right as a key Medicaid financing mechanism. These provisions would affect other states as well.

Ms. Ma then continued to discuss Medicaid eligibility changes. In addition to the work requirements, Medicaid enrollees would now be required to prove twice a year that they continue to meet the eligibility requirements, instead of once a year. The federal government would require states to impose cost-sharing for services, up to $35 per service, although this excluded primary, mental health, prenatal, pediatric, and emergency care. This was like a co-payment, but in effect it would be a provider rate cut, because some patients might not be able to pay $35. Emergency care was excluded from this provision, but not specialty care. For this reason, patients who need specialty care might forgo this care and instead go to the emergency department because there was no co-pay. There were also changes to retroactive coverage. Currently, Medicaid coverage was provided retroactively for three months before an individual is determined to be eligible for Medicaid. The bill would reduce this period to one month or two months, depending on whether enrollees are part of the expansion population or traditional Medicaid enrollees.

The bill included $50 billion over ten years for a rural health transformation program. This was an effort to try to assuage concerns about the effect of the cuts on rural health and rural providers. It was unclear how these funds would be distributed across states and by states. States would have to apply for the funds by the end of this year. Details were not yet known. Ms. Ma noted that according to some estimates, the reconciliation bill would in fact reduce funding for rural health by about $150 billion, and so the $50 billion provision would cover some of this reduction but not all of it.

Certain provisions were considered but not included in the final bill: broader Federal Medical Assistance Percentage (FMAP) reductions, an FMAP penalty for states that cover undocumented individuals, and restrictions on gender-affirming care for people of all ages. An earlier version of the bill had delayed cuts to Disproportionate Share Hospitals by about six years. This provision was not in the final bill, but the University expected that there would be other vehicles this year to delay these cuts.

These provisions would result in health coverage losses and reduced access to primary, specialty, and inpatient care. Patients would likely forgo care and come to the emergency department as their primary source of care, which was much more costly. The bill was expected to affect the financial sustainability of healthcare providers such as community hospitals. There would likely be longer waits for care at UC medical centers. UC already turned away thousands of transfer requests and referrals from other hospitals, and this situation would likely worsen. There would be an impact on all Californians needing care, not just those who are covered by Medi-Cal.

UC Health would monitor the federal implementation process. Many details were not yet known and UC expected them to emerge over the coming months and years. UC would continue to monitor federal rules and administrative actions regarding Medicaid. UC Health would continue to partner with FGR and campus governmental relations staff to educate policymakers about the impact of this bill. There were many House Republicans who expressed concerns about cuts but voted for the bill. UC would work with others to ensure that these representatives understand the impacts as this bill is being implemented, and work with the State as it begins to implement the provisions and deal with the fiscal

impact. The bill was a large shift of costs to the State. If there were opportunities, UC would advocate for a delay of funding cuts, since not all the provisions in the bill would take place right away.

Regent Park asked when the new provider tax rules would be implemented. Funds were now frozen, and she asked when the current taxes would be disallowed. Ms. Ma believed that this would occur when the State receives notification to this effect from the Centers for Medicare and Medicaid Services (CMS).

Regent Park asked if federal agencies must go through a rulemaking process to do this. Ms. Ma responded in the negative. The reconciliation bill was in effect. CMS had a proposed rule on provider taxes which was identical to the legislation and would be finalized at some point this year. It did not appear that rulemaking was required.

Regent Park commented that this effect on provider taxes seemed to be one of the largest near-term vulnerabilities and would create a large budget gap. Ms. Ma expressed agreement. UC Health has submitted a comment letter expressing concerns about this. Dr. Rubin recalled that cuts to State-directed payments would begin in January 2028, and this left a certain amount of time. UC Health was not so dependent on State-directed payments that the impacts of curtailing growth would not be digestible. He expressed concern about the effects of these cuts on public hospital systems.

Staff Advisor Frías asked if UC Health had a sense of how many UC patients would become uninsured. Ms. Ma responded that she did not have data specifically on UC patients. It was estimated that between 1.5 million and two million people in California would become uninsured as a result of the provisions in the reconciliation bill. This shifted many costs to the State, and the State would have to make further decisions on how to balance its Medicaid budget. Unless the State is able to generate new revenues to offset federal cuts, the State would have to make reductions to the program as well. The State might have to make choices between cutting eligibility and benefits or provider rates.

Advisory member Marks observed that almost all states were struggling with some of the problems mentioned in this discussion in the wake of the reconciliation bill. She expressed concern that the budget reconciliation bill would not be the only vehicle for cutting Medicare, Medicaid, and/or provider funding. She asked about possible additional cuts beyond the reconciliation bill. There had been many attempts to cut site of service payments, Disproportionate Share Hospital money, and the 340B Program. Any such actions could have seismic impacts on academic health institutions, and she asked if efforts like this were continuing. Mr. Springfield responded in the affirmative. UC Health has been advocating regarding site neutrality and hospital outpatient department cuts. There might be further reconciliation bills and further attempts to cut State-directed payments, the 340B Program, and other programs. This was a matter of concern that UC Health would monitor.

Ms. Marks asked if there were efforts by national organizations such as the Association of American Medical Colleges (AAMC) to focus on these issues. Mr. Springfield responded

that discussions with these national associations were ongoing, with a focus on potential future developments.

The meeting adjourned at 4:55 p.m.

Attest:

Secretary and Chief of Staff