UNIVERSITY OF CALIFORNIA, OFFICE OF THE PRESIDENT RESTRUCTURING EFFORT:

UC HEALTH DIVISION

Advisory Committee's Final Report of Findings and Recommendations

October 3, 2018

UNIVERSITY OF CALIFORNIA

RESPECTFULLY SUBMITTED BY

UC Health Advisory Committee

Chair

1. Steven Lipstein, Former President & CEO BJC HealthCare; Advisor, UC Board of Regents, HSC

Committee Members

2. Pradeep Khosla, Chancellor, UC San Diego
3. Mark Laret, Chief Executive Officer, UCSF Health
4. Kelsey Martin, Dean, David Geffen School of Medicine at UCLA
5. Gary May, Chancellor, UC Davis
6. Robert May, Distinguished Professor, UC Davis; Chair, Academic Senate
7. Rachael Nava, EVP-Chief Operating Officer and Chief of Staff to the President
8. Richard Sherman, Regent, UC Board of Regents, Health Services Committee

Advisor to the Committee (non-voting)

9. Dr. John Stobo, Executive Vice President, UC Health Division

Staff to the Committee

1. Kathy Eftekhari, Senior Organizational Consultant, Strategy & Program Management Office, UCOP
2. Gale Sheean-Remotto, Organizational Consultant, Strategy & Program Management Office, UCOP

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EXECUTIVE SUMMARY

REVIEW PURPOSE

In January 2018, President Napolitano launched a comprehensive restructuring effort for the University of California's Office of the President. As part of this restructuring effort, the President appointed an Advisory Committee (AC) to determine a set of recommendations specifically for the UC Health Division Office (herein after, UC Health). The Committee was asked to explore all structural, funding, and associated governance options that would enhance UC Health's agility and flexibility to reach long range strategic objectives while at the same time ensuring continued transparency, accountability, and integration within the University system.

SCOPE AND METHODOLOGY

The scope of this review was limited to the UC Health Division office at UCOP, its employees and the functions they perform.

The review process began in May 2018 with the identification of problems/challenges limiting UC Health's ability to serve the academic medical enterprise and guiding principles were developed. The division's budget, functions, headcount and strategic plan were examined along with UCOP governing structures and documents. The Advisory Committee was asked to specifically weigh the options for change presented by Huron Consulting Group (listed below) in their January 2018 report to determine whether they would effectively provide solutions to identified problems.

Huron Options[1]	
Location of UC Health Division Office	
Make the UC Health Division a standalone entity, or "location," within the UC System led by an Executive Vice President who reports to the President and governed by a committee of interested stakeholders, including Chancellors. This new "location" would be separate administratively from UCOP	
Funding for the UC Health Division Office	
Fund the UC Health Division or separate "location" by a separate assessment to the clinical enterprise only, which would be determined by a governance committee. This assessment would be in addition to other UCOP-related assessments to which the Academic Medical Centers currently contribute	
Location of Self-Funded Health Plans	
a	Move Self-Funded Health Insurance Program/s from UC Health to the Human Resources Department within the Chief Operating Officer Division at UCOP
b	Move Self-Funded Health Insurance Program/s from UC Health to the Risk Services Department within the Chief Financial Officer Division at UCOP
Location of Student Health & Counseling (Including Medical Oversight of UC SHIP)	
Move Student Health & Counseling (including medical oversight of UC SHIP) from UC Health to the Student Affairs Department within the Academic Affairs Division at UCOP	

[1] Note: Huron also listed an option for "maintaining status quo" under each of the four option groups

A systemwide stakeholder survey was distributed to elicit perceived risks and benefits of the Huron options, and to identify questions and other possible solutions; 49 of 67 responded (73%). This report with findings and draft recommendations was also distributed to the same stakeholders for further input; 18 responses with comments were received. After careful consideration of input from all stakeholders (highlighted later in this report and summarized in Appendix A), the Advisory Committee then developed the enclosed set of recommendations to address operational challenges while mitigating perceived administrative risks.

UC Health Background

The UC Health Division (26 Full-Time Equivalents - FTEs), led by an Executive Vice President, is one of twelve divisions within the Office of the President. Established ten years ago as a shared academic medicine leadership and services function inside the Office of the President, UC Health has evolved over the past decade to be the catalytic agent that helps UC's six academic health systems (including 12 hospitals) and 18 health professional schools achieve collaboratively what they otherwise would be unable to achieve operating independently of one another.

Its annual operating budget of approximately $20 million represents 2.3% of the total OP budget ($876.4M) and has three distinct fund sources: State General Funds (or campus assessment) ($4M), health systems[2] ($12M) and health plan fees ($4M).

During the past decade, the UC health professional schools and clinical enterprise have grown significantly to become one of the nation's largest health systems and now constitute a substantial segment of the human, physical, and financial assets of the University. Each of the UC academic medical centers has earned a place among US News & World Report's "Best Hospital" rankings, with UCSF and UCLA being among the top ten best hospitals in the nation.[3]

The clinical services revenue generated by these health professional schools and teaching hospitals, together with their extramural biomedical research funding, represent approximately 48% of all University revenue, just over $16 billion. The University has come to rely upon patient care revenues to provide essential financial support to the campuses and medical schools. As of October 2017, medical center FTEs numbered just over 38,000, which constitutes approximately 23.7%[4] of the total UC workforce, growing at a rate that is two times faster than that of the rest of the University.

Statement of the Problem

During this period of expansion, the health care marketplace has also changed. The U.S. population is aging and the number of new Medicare patients is on the rise. Medicaid expansion has significantly impacted payer mix at UC's health systems, causing total revenues to grow at a slower pace than patient volume and cost. Consolidation of hospitals into regional and national networks is viewed to be critical for

[2] "Health systems" refers to the clinical enterprises including the medical centers and the schools of medicine (clinical revenues)
[3] Source: https://patch.com/us/across-america/these-are-best-hospitals-america-us-news-world-report
[4] Source: https://www.universityofcalifornia.edu/infocenter/employee-fte

long-term financial success and has increased competition across California. The UC health enterprise has been increasingly challenged by a highly competitive health care environment while facing growing fiscal constraints associated with government divestment in healthcare and higher education, declining reimbursements, rapid consolidation, unpredictable health policy changes, changing demographics and growing patient demand. This environment requires creative solutions, agility, systems integration, and the ability to scale and to effect rapid, strategic growth.

Even with its record of accomplishment, there remains untapped collaborative potential across the UC health sciences campuses and medical centers. Greater "systemness", well executed, has the potential to enhance the University's academic mission, sustain and strengthen its clinical excellence, and provide much needed investment capital to keep pace with increasing demand and advances in science and technology.

With the objective of catalyzing greater systemness, the UC Health Division recently completed a strategic plan outlining 12 distinct goals that directly respond to needs articulated by their systemwide stakeholders (Listed in Appendix D). This plan, reviewed by the President and the Health Services Committee in fall 2017 outlines strategic initiatives/functions which will require the addition of approximately 45 new employees located on the campuses and within the UC Health Division at OP over the next three years (Outlined in Appendix E). While there has been demand by campus and medical center leadership for additional centralized services that will lead to greater synergy (e.g., UC cancer consortium, health data sharing, Medicaid reimbursement, pharmacy strategy, etc.), UC Health's ability to provide needed administrative and operational support has been constrained.

Following the 2017 State Audit, UCOP's budget and headcount have been scrutinized and subsequently restricted. Operational budgets and FTE tied to OP are being held flat and, with ongoing volatility of state funding, will undoubtedly face continued uncertainty. Moreover, the division has expressed difficulty entering into contracts in a timely fashion due, in part, to UCOP's administrative controls and has faced challenges recruiting talent with health care expertise utilizing UCOP pay-scales and recruiters who do not specialize in the health care professions/market. These challenges have been exacerbated by administrative deficiencies within the UC Health Division that are in the process of being remediated. There are currently approximately 25 open positions (though not fully funded) within the Division and the development of a comprehensive staffing plan tied to the Division's strategic plan is needed. Finally, the need for improved transparency and accountability with regard to UC Health's operations was noted by a number of stakeholders, including leaders of the UC Health Division itself.

The Office of the President serves as a systemwide leadership, policy, compliance and service organization in support of the University of California's teaching, research and public service mission. The systems and processes put in place have been developed and honed over time to mitigate risk and to ensure and enhance consistency and excellence across the system. It may be argued, however, that the mechanisms within OP were not designed to effectively support the market-driven management service requirements of one of the nation's largest health care systems.

While these challenges affect all UCOP divisions, each of which provides critical services and functions in support of UC's mission, demands of the health care marketplace may require greater flexibility in how the university approaches its support of the academic medical enterprise. Said another way, both the

University and its clinical enterprise want to sustain excellence, competitiveness and financial health, but the clinical enterprise may need to be resourced differently than UCOP to achieve these shared objectives.

RECOMMENDATIONS

After reviewing the scope and impact of current operational challenges within UC Health along with careful consideration of stakeholder input with respect to various possible solutions (risks and benefits of each outlined later in this report), the Advisory Committee unanimously concluded that the following recommendations, if approved, could provide the UC Health Division office the increased agility and flexibility it needs to support the academic medical centers and health professional schools, while assuring transparency, minimizing risk and disruption, and maintaining the integrity of current structures of authority and decision-making across the UC system. It should be noted that even while this report was being drafted, the UCOP landscape was changing - a new recruiter with health care experience was hired, the FY18-19 OP budget was approved and the Major Projects and Initiatives Process threshold was increased. These changes partially address some of the challenges identified and outlined in this report and are reflected in the recommendations being forwarded for consideration below:

Location & Governance of UC Health

1. The UC Health Division should remain a division of UCOP.
2. To enable the University's health systems to further develop and expand, pay for, and execute strategies that will allow them to achieve collaboratively what they would otherwise be unable to achieve operating independently of one another, UC Health Division activities should be disaggregated into two distinct sub-divisions, each with its own operating budget.
   a. The first sub-division and associated budget would include all UC Health Division functions/activities that are funded by the UCOP core operating budget (state general funds) and by fees charged to the self-funded health plans.
   b. For purposes of this Report only, we have given the second sub-division a placeholder name to help convey its primary purpose: *The UC Healthcare Collaborative (UCHC).* The UCHC and its associated budget would include all UC Health Division functions/activities that are funded solely by the health systems via cost-transfer (the source of funds will be clinical revenues). As all expenses of this sub-division would be borne by the health systems, the Committee recommends that the President and the Regents exclude its operating budget and associated FTE from the growth limitations imposed upon other UCOP divisions to allow for the development and growth of essential collaborative programs and services. *(For those readers familiar with UCOP budgeting procedures, this sub-division would simply become a separate sub-line-item of the Heath Services Division budget, and recorded as such on Schedule D.*).
   c. Both sub-divisions should be positioned under the UC Health Division inside UCOP, reporting to the EVP to take full advantage of already existing governance and management infrastructure. The EVP for UC Health would continue to report to the President.
   d. Both sub-divisions, their currently funded activities and future investments should be guided by the UC Health Strategic Plan, which should be evaluated at least annually and updated if/as necessary with stakeholder input to ensure that the Plan remains responsive to the clinical, teaching and research missions of the University in a rapidly changing healthcare environment.
   e. Both sub-divisions would continue to follow the same policies and processes that apply to all other UCOP divisions (except the budget and FTE exception noted in 2b). However, as is described in the report, there are substantive differences between managing/operating a

university and managing/operating a healthcare delivery system. To provide the flexibility and agility that the health care enterprise will require in the coming years, UCOP leaders and staff should take these differences into account as UCOP polices and processes pertain to the UCHC.

3. No changes to existing governance. The UC Health Division of UCOP, the UC medical centers and health professional schools should continue to be governed by the Regents' Health Services Committee, and other Regental committees that currently oversee health related activities across the UC system. The Executive Vice President of UC Health should continue to report to the UC President.

4. No changes to existing structure. The UC health professional schools and medical centers should continue to be organizationally aligned with the campuses where they reside, with no changes to the current governance, management, reporting relationships, and authorities.

Improved Transparency and Accountability

5. To ensure transparency and accountability, the Executive Vice President for the UC Health Division of UCOP should provide briefings on the operating budget of the UC Health Division and the UCHC (including sources and uses of funds), as well as reports of progress regarding the UC Health Division Strategic Plan to the Health Services Committee of the Board of Regents, the Executive Budget Committee of UCOP, and the Council of Chancellors.

6. More frequent, structured, and systematic involvement of the chancellors in policy development, strategy formulation and funding decisions should be developed and implemented. By December of this year and annually thereafter, the EVP of UC Health should present the proposed budget for the UCHC to the chancellors of the six campuses with health systems for review and recommendations to the Executive Budget Committee who will then make recommendations to the President for approval. The EVP should also provide an overview of the components of UC Health's strategic plan relevant to the UCHC, and provide quarterly updates thereafter to coincide with Council of Chancellor meetings. For proposed projects and spending that arise off cycle, the EVP should also present items to these same chancellors for their review and recommendations to the President for approval.

7. To ensure the optimal internal structure and operational effectiveness within the UC Health Division office, the division should move forward as soon as possible with Goal #7 in their Strategic Plan – completing an organizational review and staffing plan that will outline needed positions and an effective recruiting and on-boarding timeline in order to best achieve the division's goals. The staffing plan should include a pro forma delineation of which FTEs will be funded by the first subdivision, and which will be funded by the second subdivision - the UC Healthcare Collaborative.

Improved Operational Effectiveness

8. Following a year of evaluation, to improve UCOP's ability to respond to market and stakeholder demands (including those of the UC Health Division), the President has modified the Major Projects and Initiatives (MPI) process to increase the threshold amount (per project or initiative) up to $300,000 from $100,000. The Advisory Committee recommends that after a specified trial period, UCOP evaluate the types and cost of projects and initiatives submitted by UC Health through the MPI process and if there are no fiscal control or operating issues of concern, consider raising the threshold. MPI threshold levels above $300,000 could be piloted and evaluated for the UC Health Division.

9. To address challenges associated with compensation, add specialized health-related responsibilities and/or qualifications to UCOP's library of job standards under Career Tracks. Until this is implemented, the Advisory Committee recommends that UC Health be allowed to utilize UCSF Career Tracks for similar UCOP positions.
10. To facilitate recruitment of professionals to the UC Health Division, OP Human Resources has just hired a dedicated health care recruiter. This new HR professional started in August 2018. No later than the end of June 2019, the EVP of UC Health and the COO of UCOP together should evaluate the effectiveness of this new OP HR recruiter and report their findings and conclusions to the President.
Self-Funded Health Plans
11. If the recommendation to keep UC Health within UCOP is accepted, the Advisory Committee recommends that UC Health should retain its current role in administration of the self-funded health plans. It is beyond the scope of the Committee's charge to evaluate the plan structure and offerings of University employee health benefits; the Committee nevertheless believes that a thorough evaluation of the University's approach to employee health benefits would be timely and important.
Student Health & Counseling
12. To maintain critical medical oversight of Student Health and Counseling, the Chief Medical Officer and the functions of this position for Student Health and Counseling should continue to report to the UC Health Division of UCOP.
13. To address reported concerns of leaders of campus-based Counseling and Psychological Services (CAPS) about growing student demand for their services and a perceived lack of a coordinated, strategic response, the Committee recommends "listening and learning sessions" facilitated jointly by UC Health and Student Affairs, to include Vice Chancellors of Student Affairs, Student Health & Counseling leaders, and other UCOP and campus leaders with a mandate to develop and implement a coordinated action plan that addresses concerns identified by the participants.

IMPLEMENTATION CONSIDERATIONS

While implementation is outside the scope of this review, it is recognized that implementation of any approved changes will require further administrative action and that additional decisions will need to be made around protocol, timing, processes and resources. The Advisory Committee would recommend that these decisions be made with systemwide input where possible and that all changes be in place by the beginning of the next fiscal year (FY19-20). The following is a list of recommended early implementation steps:

1. Define a clear process by which the existing UC Health Division operating budget will be disaggregated into two distinct subdivisions
2. Develop a staffing plan for UC Health Division open positions that encompasses both sub-divisions and is derived from the UC Health Division Strategic Plan
3. Add specialized health-related responsibilities and/or qualifications to UCOP's library of job standards under Career Tracks
4. Post and fill UC Health Division open positions
5. Convene systemwide Student Health and Counseling Directors for first "listening and learning" session and begin the development of strategies to address identified issues
6. Create and execute a staff and stakeholder communication plan regarding any approved changes

CONSULTATIVE PROCESS OVERVIEW

PURPOSE

In January 2018, President Napolitano launched a comprehensive restructuring effort for the University of California's Office of the President. As part of this restructuring effort, the President appointed an Advisory Committee (AC) to determine a set of recommendations specifically for the UC Health Division Office. The Committee was asked to explore all structural, funding, and associated governance options that would enhance UC Health's agility and flexibility to meet long-range strategic objectives while at the same time ensuring continued transparency, accountability, and integration within the University system.

SCOPE & METHODOLOGY

The scope of this review was limited to the UC Health Division office at UCOP (UC Health), its employees and the functions they perform.

The review process began in May 2018 with the identification of problems/challenges limiting UC Health's ability to serve the academic medical enterprise. The division's budget, functions, headcount and strategic plan were examined along with pertinent UCOP governing structures and processes. The Advisory Committee was asked to specifically weigh the options for change presented by Huron Consulting Group in their January 2018 report (listed below) to determine whether they would effectively provide solutions to identified problems. It should be noted that Huron's suggestion that OP consider making the UC Health Division a "stand-alone" entity in order to enhance its overall efficiency and effectiveness was not a new concept. Solutions for providing greater operational flexibility, including this one, were being weighed prior to Huron's engagement but were put on hold to allow for the completion of the Huron review. Note that Huron also listed an option for "maintaining status quo" under each of the four option groups below.

Huron Options	
Location of UC Health Division Office	
Make the UC Health Division a standalone entity, or "location," within the UC System led by an Executive Vice President who reports to the President and governed by a committee of interested stakeholders, including Chancellors. This new "location" would be separate administratively from UCOP	
Funding for the UC Health Division Office	
Fund the UC Health Division or separate "location" by a separate assessment to the clinical enterprise only, which would be determined by a governance committee. This assessment would be in addition to other UCOP-related assessments to which the Academic Medical Centers currently contribute	
Location of Self-Funded Health Plans	
a	Move Self-Funded Health Insurance Program/s from UC Health to the Human Resources Department within the Chief Operating Officer Division at UCOP
b	Move Self-Funded Health Insurance Program/s from UC Health to the Risk Services Department within the Chief Financial Officer Division at UCOP
Location of Student Health & Counseling (Including Medical Oversight of UC SHIP)	
Move Student Health & Counseling (including medical oversight of UC SHIP) from UC Health to the Student Affairs Department within the Academic Affairs Division at UCOP	

A survey was designed and distributed to key stakeholders to elicit perceived risks and benefits of each of the Huron options and to identify questions and other possible solutions. Stakeholders that received the full survey included all Chancellors, Medical Center CEOs, Health Sciences Deans, the Health Care Taskforce (Academic Senate), and a variety of UCOP administrators; 49 of 67 responded (73%). Prior to sending the survey, briefings were held with each stakeholder group to provide an overview of the perceived problems and to explain the Huron options. During these briefings it was determined that there was an insufficient number of stakeholders on the above list who might have insight regarding Huron's proposal to move the medical oversight of student health and counseling from UC Health to Academic Affairs. In order to better understand the perspectives of those in the field, an abbreviated survey was sent to the Student Health Center (SHC) Directors and Counseling and Psychological Services (CAPS) Directors on each campus regarding this specific option; 11 of 20 responded (55%). This report with findings and draft recommendations was also distributed to the same stakeholder groups for further input; 18 responses with comments were received. A full summary of all stakeholder comments is included as Appendix A.

After careful consideration of input from all stakeholders, the Advisory Committee then developed the enclosed set of recommendations to address operational challenges while mitigating perceived administrative risks.

GUIDING PRINCIPLES

After developing a better understanding of the problems facing UC Health, UCOP and the academic medical enterprise, the following guiding principles were developed to guide the Advisory Committee's thinking in the development of recommendations. These principles were initially outlined by the Advisory Committee and were amended with input from stakeholders throughout the review process.

1. Enable the UC Health Division office at UCOP to prioritize and optimally support the University's academic mission and its clinical enterprise
2. Position the UC Health Division to enable the 6 academic health systems and 18 health professional schools to each achieve its own unique success by doing what they cannot independently do for themselves -- coordination, collaboration and maximization of economies of scale
3. Balance systemwide benefit with local uniqueness, authority and control
4. Maintain the current authority of the Regents, the President, and Chancellors
5. Ensure transparency and accountability regarding the source and use of resources that support the activities of the UC Health Division office at UCOP
6. Position the UC academic medical enterprise to compete successfully at the local and state and national levels
7. Be informed by stakeholder input and strive for solutions that are mutually beneficial and that will benefit the University as a whole
8. Build towards a "future state" that is designed to last beyond the current systemwide leadership

FINDINGS

UC HEALTH DIVISION OVERVIEW

The UC Health Division (26 FTEs), led by an Executive Vice President, is one of twelve divisions within the Office of the President. This office provides leadership and strategic direction for UC's six academic health systems (including 12 hospitals) and 18 health professional schools. Its annual operating budget of about $20 million represents 2.3% of the total OP budget ($876.4M) and has three distinct fund sources: State General Funds (or campus assessment) ($4M), health systems ($12M) and health plan fees ($4M). The source and use of funds is outlined in the table below.

Fund Source	Programs/Function	FY18-19 Budget
Core Funding *1	Immediate Office	$2.7M
	Health Sciences/Academic Initiatives	$0.9M
	Student Health Centers	$0.3M
	Strategy Planning & Policy	$0.1M
	Core Funding Subtotal	$4.0M
Health Systems Funding *2	Strategy Planning & Policy	$1.4M
	Contracting with Commercial Insurers	$0.5M
	Leveraging Scale for Value (LSfV)	$4.9M
	Center for Health Quality & Innovation(CHQI)	$0.3M
	Center for Data Driven Insights and Innovation	$4.1M
	Office of Quality and Population Health Mgmt.	$1.2M
	Health Systems Funding Subtotal	$12M
Health Plan Premiums *3	Self-funded Health Plans	$4.1M
	TOTAL	**$20.5M**

1. *Core Funding is allocated from UCOP to support non-clinical related activities of UC Health division*
2. *Health system Funding is assessment collected from health systems (clinical enterprises including the medical centers and the schools of medicine - clinical revenues) for cost saving initiatives and health quality and innovation programs*
3. *Self-funded Health Plans administrative costs are funded from Health Plan Premiums*

Established ten years ago as a shared academic medicine leadership and services function inside the Office of the President, UC Health has evolved over the past decade to be the catalytic agent that helps UC medical centers and health professional schools achieve collaboratively what they otherwise would be unable to achieve operating independently of one another.

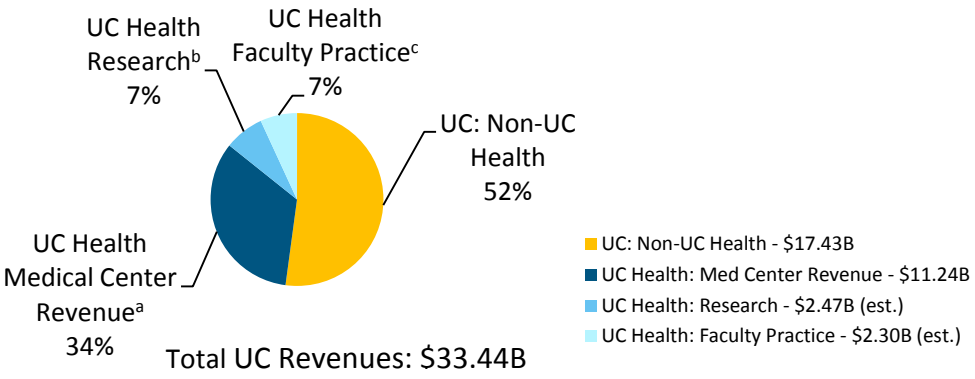
UC Health is a vehicle for sharing best practices and creating systemness across the academic medical enterprise by coordinating systemwide purchasing and contracting activities, promulgating systemwide standards of clinical and service quality, and enabling the various campuses to organize themselves into a statewide health care delivery network. Within the UC system, UC Health is a centralized resource with health care expertise, offering strategic counsel and policy guidance to UCOP and campus leadership. UC Health also provides effective and innovative leadership of the University's self-funded employee health plans, and clinical oversight of the University's student health and counseling services.

In 2011, the Center for Health Quality Innovation (CHQI) was developed within UC Health and funded by the health systems to drive systemwide clinical improvement. As of 2016, it is estimated that CHQI-funded projects and programs have generated more than $65 million in systemwide benefits, including multiple publications and innovative contracts for clinical services. These have resulted in decreases in lengths of stay, complication rates and readmissions. UC Health's goal for CHQI is that it continue to evolve into a data-driven, system-level quality and population health management function that will identify best practices across the system to improve the quality and efficiency of care delivery and patient outcomes and reduce costs. UC Health also manages *Leveraging Scale for Value*, a systemwide cost initiative launched in 2015, which has since generated over $750M in systemwide cost reductions with a goal of achieving an additional $500M per year going forward. Both of these programs are funded solely by the health systems.

UC Health Enterprise Growth

Over the past 10 years, UC health professional schools and the clinical enterprise have grown and now constitute a substantial segment of the human, physical, and financial assets of the University. As of October 2017, medical center FTEs numbered just over 38,000, which constitutes approximately 23.7%[5] of the total UC workforce. The clinical services revenue generated by these health professional schools and teaching hospitals ($13.54 billion), together with their extramural biomedical research funding ($2.47 billion), represent approximately 48% of all University revenue, just over $16 billion. The University has come to rely upon patient care revenues to provide essential financial support to the campuses and medical schools.

Total UC Revenues: Fiscal Year 2016-2017[6]



[5] Source: https://www.universityofcalifornia.edu/infocenter/employee-fte

[6] Sources: 2017 Annual Accountability Report; 2016-2017 Annual Financial Report; 2016-2017 Research Funding by Discipline (IRAP Chart); Revenue and Expense Trends Fiscal Years 2013 through 2017; 2016-2017 Annual Report on University Private Support. Notes: Revenues include some philanthropy but exclude philanthropy associated with UC Health; [a]Includes UC San Francisco Faculty Practice; [b]Research Funding by Disciplines "Medicine" & "Other Health Sciences"; [c] Self-reported, FY 2015-2016

The University of California's academic health system is one of the largest in the country and there is much evidence to suggest that the UC clinical enterprise (defined as all clinical staff employed by the University and the health care facilities owned by the University) will likely continue to grow at a rate that outpaces the rest of the University, causing new pressure points that will challenge University regents and leaders. Since 2010, following passage of the Affordable Care Act, the UC medical centers have experienced a 9% compounded annual growth rate (CAGR) in revenue, two times the growth rate of all other University revenues[7]. If this trend continues, by 2032 (15 years from now), medical center revenue will exceed all other University sources of revenue combined. Between 2010 and 2017, the growth rate of full-time equivalent employees (FTEs) in the medical centers was nearly double that of all non-medical center FTEs combined, 3.8% CAGR and 2.0% CAGR, respectively.[8]

Each of the medical centers within the UC system has achieved remarkable improvements in financial and operating performance over the past decade while earning a place among US News & World Report's "Best Hospital rankings as shown in the table below:[9]

Best Hospitals - Nationally	#5 UCSF	#7 UCLA			
Best Hospitals - California	#1 UCSF	#2 UCLA	#5 UCD	#7 UCSD	#11 UCI

Much of this progress can be credited to local leaders, faculty and staff. Each medical center also has expanded its regional capacity to better serve the major population centers of California.

Even with this impressive record of accomplishment, there remains untapped collaborative potential across the UC health sciences campuses and medical centers. Greater "systemness", well executed, has the potential to enhance the University's academic mission, sustain and strengthen its clinical excellence, and provide much needed investment capital to keep pace with increasing client demand and advances in science and technology.

With the objective of designing and implementing greater systemness, the UC Health Division recently completed a strategic plan outlining 12 distinct goals that directly respond to needs articulated by their systemwide stakeholders. See Appendix D for a full summary of stakeholder needs and UC Health goals.

Operating within the Current Health Care Market

It is important to acknowledge that almost all UC patient care revenue comes from three external payment sources: the federal government (primarily Medicare and Medi-Cal); the state government, and private sector payers that include commercial insurance companies and employer self-funded health plans.

These external sources will experience mounting financial pressures in the coming decade. The federal government is operating with a sizable budget deficit, with the public debt increasing at an unsustainable

[7] Appendix B – University of California Revenue Growth Analysis
[8] Appendix C– University of California Full-Time Equivalent (FTE) Growth Analysis
[9] Source: https://patch.com/us/across-america/these-are-best-hospitals-america-us-news-world-report and https://accountability.universityofcalifornia.edu/2018/chapters/chapter-11.html

rate. State government has always operated under severe fiscal constraints. There is broad consensus that health insurance premiums are becoming unaffordable for many Californians. An aging population portends future deficit spending for the Medicare Trust Fund (now forecasted to begin in 2026), as the numbers of beneficiaries grow and as the number of working Americans (paying Medicare payroll tax) shrinks when the baby boomers retire.[10]

Anticipating future payer restraints on pricing increases, and fiscal constraints associated with government budget deficits, academic medical centers are especially vulnerable. In addition to the federal government payments that teaching hospitals receive for taking care of Medicare patients, they receive supplemental Medicare revenue streams for the direct costs of medical education (residency training stipends and supervision), the indirect costs of medical education (teaching hospitals' enhanced service delivery missions), and often, a more acutely ill patient population (outlier payments). These supplemental revenue streams are substantial and for many teaching hospitals, equal or exceed their operating margins.

While the financial and operating constraints recently imposed upon the University's Office of the President (UCOP) by the State Legislature may be challenging for today's UC leaders, they are happening in the context of federal and state budget pressures, and the looming health care affordability crisis. The "business model" of the national health care delivery system will come under increasing financial pressure. Operation of the UC academic medical enterprise is entwined within this national business model and will, therefore, experience the same pressure.

Consolidation of hospitals into regional and national networks has proven to be critical for long-term financial success and the diversification and dispersion of population health risk. As these consolidated systems increase in size and sophistication, competition within local UC markets has also increased. The health systems that will thrive in the future must get bigger. As health care systems transition towards "value-based care" or "accountable care" (i.e., being rewarded for patient outcomes and quality versus the volume of services rendered), they need to diversify and disburse the financial risk. They need to spread fixed operating costs (facilities, equipment, supply chain, revenue cycle, information technology, clinical engineering) over a larger and larger base of activity/revenue to keep the per-unit cost of non-clinical functions as low as possible.

Human talent will migrate to the "winners" – opting for those systems that are successful and that are perceived as well positioned for the future. Operating surpluses will accrue to those systems best able to lower operating costs while maintaining superior quality of clinical care outcomes and service. The combination of the best people and the most money will be a winning formula.

The examples of academic medical centers "getting bigger" by forming state-wide and multi-state integrated delivery systems are pervasive: Partners Health Care (MA, RI), Mayo Clinic (MN, AZ, FL), Johns Hopkins (MD, FL, DC), Cleveland Clinic (OH), Vanderbilt (TN), Emory (GA), Duke (NC), University of North Carolina (NC, SC), University of Colorado (CO), University of Pittsburgh (UPMC), University of Indiana (IN).

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[10] Source*:* https://www.cbo.gov/system/files?file=2018-06/53919-2018ltbo.pdf*; The 2018 Long-Term Budget Outlook*, June, 2018

Conversely, very few hospitals/physician groups have achieved success and sustainability as stand-alone enterprises. Those that remain independent tend to be facilities and practices located in affluent geographic markets. Health care systems are either growing through acquisition, affiliation or collaboration - or are being absorbed into larger organizational frameworks.

It is clear that over the past decade - a period of expansion and success for the UC academic medical enterprise - the health care marketplace has also changed. The current environment requires creative solutions, agility, systems integration, and the ability to scale and to effect rapid, strategic growth.

Challenges Within the UCOP Operating Environment

While there has been demand by campus and medical center leadership for additional systemwide shared services, UC Health's ability to respond has been limited by administrative constraints and the impact of political pressures on UCOP.

2017 State Audit Impact

The 2017 California State Auditor's Report of UCOP has resulted in scrutiny by the Legislature and Regents, effectively freezing OP budgets and FTE growth. Although UCOP has accepted and made progress on the implementation of the State Auditor's 33 recommendations, the State Legislature, in 2017 and 2018 prohibited UCOP from assessing the campuses directly for administrative services, programs and initiatives. UCOP instead receives a prescribed amount from its State General Funds allocation. UC Health's core funding of $4M is tied to this allocation.

There are a few limited exceptions to this restriction, including, in 2018, part of a separate campus assessment for UCPath operational costs and debt service, and other financial transactions (transfers, recharges, etc.) that routinely occur between campuses and the Office of the President. These are not included in the general campus or UCPath assessments reflected in the Budget Act because they typically reflect an assessment, fee, or fund transfer for a specific use (e.g., reimbursements for vendor payments that are made by UCOP on behalf of campuses and medical centers). Examples of such programs/transactions for 2017-18 were cited in a letter from President Napolitano to the Department of Finance in August 2017; there were only two UC Health program exceptions listed – Leveraging Scale for Value and the Center for Health Quality and Innovation (CHQI).[11] The UC Health budget for these two programs ($12M) is paid directly by the medical centers and has always been separate from any other UCOP assessment to the campuses. Should UC Health wish to add additional programs (health data or a cancer care consortium, for example) at the request or with the approval of their stakeholders, UCOP would need to notify the Department of Finance.

Because UC Health's entire budget (regardless of fund source) is reflected on the OP books, any increase in funding or FTEs for programs resourced by the medical centers would also raise the overall OP budget and headcount, which OP and the Regents have determined should be held flat for the FY18-19 year.

[11] Source: August 17,2017 letter from President Napolitano to Director Michael Cohen, CA Department of Finance

UCOP Administrative Controls

In order to provide coordination and oversight of spending on UCOP's major projects and initiatives across all divisions, the Major Projects and Initiatives (MPI) Proposal process was put into effect on July 1, 2017. The process outline posted on the OP website states that proposals for one-time funds for projects and initiatives over $100,000 from any fund source - even if there is an approved line item in the department budget allocation - must follow the MPI Proposal process. MPI Proposals are reviewed quarterly by both a Submission Review Team and a Review Committee, and are approved at the discretion of the President. Departments must meet quarterly deadlines and there is a 30-day turnaround for review and decision on all MPI submissions. Due to the detailed level of reviews and number of reviewers involved in the process, expedited processing is challenging. It is preferred that all submissions go through the quarterly review cycle.[12]

The MPI process was put in place to ensure leadership had the opportunity to review, prioritize, and allocate resources to projects and initiatives launched from OP, and to ensure communication and coordination across OP divisions, especially regarding the acquisition and integration of new technology. This process did not change the already existing requirement that professional contracts which support operational needs must be forwarded to the President for approval; it simply raised the threshold from $20,000 to $100,000.

While the MPI process has proven effective with regards to its intended purpose, UC Health has expressed that the $100,000 threshold coupled with quarterly submission deadlines and an unclear path for engaging outside expertise on short order, can create challenges for an organization that needs to respond quickly to competitive opportunities, threats and regulatory and reputational issues in the complex and rapidly evolving health care industry. Coincidentally, on July 25, 2018 (during the writing of this report), President Napolitano reviewed the MPI process and accepted a proposal to raise the threshold amount to $300,000.

Given that the MPI process was not intended to block the engagement of critical consulting expertise or the launch of essential initiatives, it is likely that additional communication/clarification regarding timelines, process, and the mechanism for addressing urgent requests is warranted and could help to remedy the issue.

UC Health Recruiting Challenges

The 2017-2022 UC Health Division strategic plan outlines new initiatives and related functions, requested by systemwide stakeholders, which will require the addition of approximately 45 new employees divided between UCOP and the campuses over the next three years (outlined in Appendix E). There are currently approximately 25 open, approved positions within the UC Health Division. These vacant positions were only recently confirmed during the FY18-19 budget process and adequate funding for all may not be available. The Division and OP Human Resources both recognize that a staffing plan which outlines needed positons and an effective recruiting and on-boarding timeline to meet the goals within the division's strategic plan is needed. In fact, Goal #7 within the strategic plan itself, recognizes and

[12] Source: https://www.ucop.edu/pmo/_files/Major%20Projects%20and%20Initiatives%20Proposal%20Process.pdf

articulates the need to *conduct an independent organizational review of the current and proposed staffing under the new strategic plan, an assessment of how best to utilize current staff to implement goals, and the identification of gaps in current expertise and manpower that will need to be filled*. Recruiting candidates to fill open UC Health positions, however, has been difficult for a number of reasons related to both administrative challenges within the division and UCOP processes.

UCOP utilizes Career Tracks – a systemwide job classification system which aligns pay structure to the marketplace to standardize job descriptions and pay scales for similar positions. All UC locations currently employ Career Tracks except UCLA and UC Irvine, both of which will eventually adopt the system. Cross-functional jobs – those that are performed at both medical centers and other locations – usually are classified with the same salary grade. Each location has the prerogative to set a "target percentage" of the salary scales based on local market conditions. The Systemwide Compensation Department's advice to all locations has been to use the entire range and to pay appropriately depending on the quality of the candidate. Per local OP procedure, all salary offers must be approved by the UCOP Executive Director, Human Resources.

At medical centers (e.g., UCSF), Career Tracks already includes a unique "health" classification for jobs that include specialized health-related knowledge, skills or functions. Grades for these standards are benchmarked to academic medical center data as well as other healthcare markers to reflect their value in the marketplace. UCOP's current library of job standards under Career Tracks typically does not include the specialized health-related responsibilities and/or qualifications needed by UC Health as no one has yet requested they be extended to OP. It should be noted that new Market Reference Zones (MRZs) for the Senior Management Group (SMG) were approved in January 2018 for medical centers so the salary scale issue applies only to positions below the SMG level.

In this current OP operating environment, UC Health faces several challenges in recruiting positions below the SMG level. The Division typically competes with other major nonprofit and academic health systems for talent in a highly competitive market. Not having the health classification in OP Career Tracks, has resulted in critical delays caused by the need to create and approve new job descriptions and obtain special approval for salary exceptions. These delays make it difficult for UC Health to successfully compete for candidates.

Adding to this recruiting challenge is the fact that UCOP Human Resources (HR) has not previously had a recruiter or business partner who specializes in the health care professions or health system office operations. As a result UC Health has found the creation of new positions and the sourcing of health care candidates to be challenging. However, a new health care recruiter has just been hired and joined the talent acquisition team within UCOP HR in August 2018. A stronger, more pro-active working relationship between OP HR and UC Health, especially now with the new recruiter, would help to create a stronger shared understanding of UC Health's business needs and related talent requirements, which should then streamline candidate sourcing and selection.

UCOP and Governance of a Health Care System

The Office of the President serves as a systemwide leadership, policy, compliance and service organization in support of the University's teaching, research and public service mission. The systems and processes put in place have been developed and honed over time to mitigate risk and to ensure and enhance

consistency and excellence across the system. It may be argued, however, that the resources and mechanisms within OP were neither created nor designed to effectively support the market-driven management service requirements of one of nation's largest health care systems.

While processes and restrictions affect all UCOP divisions, each of which provides critical services and functions in support of UC's mission, demands of the health care marketplace may require greater flexibility in how the university approaches its support of the academic medical enterprise. Both the University and its clinical enterprise want to sustain excellence, competitiveness and financial health, but the clinical enterprise may need to be resourced differently than UCOP to achieve these shared objectives.

PROPOSED SOLUTIONS AND PERCEIVED RISKS/BENEFITS

Huron outlined a number of options for consideration (listed below) as possible solutions to the challenges they identified during their evaluation process. The Advisory Committee was charged with formally considering these options, along with any other viable solutions during the review process. Risks and benefits of each Huron option were also elicited through a stakeholder survey and then carefully weighed by the Advisory Committee before recommendations were made. A summary of the most frequently noted risks and benefits of each of the Huron options is outlined below. A full summary of stakeholder comments is included as Appendix A.

LOCATION OF UC HEALTH DIVISION OFFICE

Huron Options re: Location of UC Health Division Office	
a	The UC Health Division remains within UCOP as it is currently.
b	The UC Health Division becomes a standalone entity, or "location," within the UC System led by an Executive Vice President who reports to the President and is governed by a committee of interested stakeholders, including Chancellors. This new "location" would be separate administratively from UCOP

In order to address the previously mentioned administrative and operational limitations within UCOP (e.g., hiring and budget constraints) and to facilitate a change that might allow the division to optimize its support of UC's medical centers and health professional schools, Huron proposed that OP consider moving the division office to a standalone entity or location. The meaning of "location" was not defined but stakeholders, nevertheless, voiced strong opinions regarding potential risks and benefits. Concerns were carefully weighed and affected the Advisory Committee's guiding principles and final recommendations.

An ill-defined option naturally raises fears and objections based on the most extreme interpretation of meaning. This was actually useful to the Advisory Committee as it helped to define the parameters of "acceptability" for change regarding UC Health and its relationship to UCOP, the campuses and the Board of Regents.

Although stakeholders surveyed (53%) agreed that UC Health's current operational structure does not allow sufficient agility and nimbleness for the Division to adequately support the system within the current health care market, the Huron option to create a separate "location" was deemed risky. Many (43%) expressed concern regarding potential separation of the academic from the clinical enterprise; others (33%) expressed concern that such a move could divide campus administration and governance structures and loosen accountability. Stakeholders (20%) also commented that the added layer of bureaucracy would duplicate efforts and be costly. Nearly half of the respondents (49%) felt that keeping the current structure would best preserve the administrative integrity of the university.

As there were *very* strong opinions regarding both of the above Huron options, the Advisory Committee sought to identify a compromise solution that would allow critical programs within UC Health to grow with financial support from the health systems on a fee-for-service basis yet anchor the division firmly to UCOP and to the academic enterprise and keep Chancellor authority intact. The concept of a Multi-Campus Service Unit/Fee-For-Service Unit/Business Unit surfaced as a possible alternative. This construct could be utilized to operate new, existing or expanded systemwide programs or initiatives (like Leveraging Scale for Value and CHQI) that benefit the health system and are funded solely by the health systems. These

programs and initiatives would be segregated within the Division operating budget into a new "subdivision" and would remain within the UC Health Division at UCOP but, if so approved by the President and Regents, could be exempt from current UCOP budget and headcount constraints. For those readers familiar with UCOP budgeting procedures, this second sub-division would simply become a separate sub-line-item of the Heath Services Division operating budget, and recorded as such on Schedule D. Such a determination would allow UC Health the flexibility to grow but would obviate the need to define, create and govern a non-UCOP entity and would help to avoid duplication of any required infrastructure.

The new subdivision and its functions would report to the EVP of UC Health but be separate from the rest of the UC Health Division budget, which would ensure: a) transparency of funding source (the health systems) and uses of those funds, and b) separation of those expenses and staff positions that would not be subject to UCOP budget and FTE caps. For the purposes of this report only, this new subdivision will herein after be referred to the *University of California Healthcare Collaborative (UCHC)*.

Funding of the UC Health Division Office

Huron Options re: Funding for the UC Health Division Office	
a	The UC Health Division or separate "location" continues to be funded by a combination of State General Funds/UCOP assessment and assessment to the clinical enterprise.
b	Fund the UC Health Division or separate "location" by a separate assessment to the clinical enterprise only, which would be determined by a governance committee. This assessment would be in addition to other UCOP-related assessments to which the Academic Medical Centers currently contribute

As mentioned previously, the overall budget for the UC Health Division office at UCOP is approximately $20M per year and currently comes from three distinct sources - State General Funds/UCOP Assessment ($4M), Health Systems Funding ($12M), and Health Plan Premiums ($4M). In order to limit the volatility and restrictions associated with State General Funds/UCOP Assessment and to allow the UC Health Division budget to be more responsive to the needs of UC Health's medical centers and health professional schools, the Huron Report proposed consideration of having UC Health funded exclusively by the clinical enterprise.

Some stakeholders (35%) agreed that funding associated with State General Funds (or the usual OP campus assessment) would be subject to greater uncertainty and restrictions and would, therefore, threaten UC Health's ability to support the academic medical system. However, 24% of stakeholders also mentioned the risk of possibly losing connection and coordination between the academic and clinical missions if all UC Health funding were to come solely from a separate assessment of the clinical enterprise.

Self-Funded Health Plans

Huron Options re: Location of Self-Funded Health Plans	
a	Keep Self-Funded Health Insurance Programs within the UC Health Division at UCOP or move it with the rest of UC Health to a new "location"
b	Move Self-Funded Health Insurance Program/s from UC Health to the Human Resources Department within the Chief Operating Officer Division at UCOP
c	Move Self-Funded Health Insurance Program/s from UC Health to the Risk Services Department within the Chief Financial Officer Division at UCOP

The University administers two sets of self-funded health plans: one for employees, retirees, and their families (the "Faculty and Staff Health Benefits Program") and the other for students (the "UC Student Health Insurance Plan," or "UC SHIP"). The Advisory Committee focused its deliberations on the Employee Health Benefits Plans. Since 2014, these plans have been jointly administered at UCOP. Human Resources & Benefits oversees eligibility, enrollment, UC budget impact, and other HR components of the Employee Health Benefits Plans, while UC Health provides plan administration services. Risk Services also plays a role in the governance of the Employee Health Benefits Plans through participation on a Joint Operating Committee that oversees plan operations, and through Fiat Lux (UC's risk and insurance company). Given that some national higher education institutions place the administration of these plans solely under Human Resources (Benefits) or within Risk Services, Huron proposed that UC consider doing the same.

The Advisory Committee examined the relative risks and benefits of all three Huron options. It was acknowledged that the decision of whether to keep plan administration under UC Health would take on greater significance if the division were to be moved to a "separate location" away from UCOP.

The self-funded plan -UC Care was launched in 2014 and initially reported under Risk Services with shared governance between UC Health and Human Resources. The administration of UC Care was transferred to UC Health in 2015. The portfolio of self-funded plans successfully administered by the UC Health Division has grown continuously since then. Some stakeholders (18%) specifically mentioned that the expertise for health care clearly lies within UC Health.

One of the fundamental reasons for self-funding a health plan is to reduce overall administrative costs. Total benefit to UC can be further enhanced by sharing premium risk with and keeping health care spend within the medical centers. Currently 47% of medical service-spend by UC Care goes to UC providers. UC Health has helped to regulate the cost of care. At the time UC Health assumed responsibility for plan administration, the medical centers made a commitment to the President that they would absorb any premium rate increases greater than 5%. After an initial right-sizing of the premium in 2015, increases have been at or below this promised rate. Taking on this risk for the health care of a defined population encourages the medical centers to focus on keeping employees and their families healthy, improving medical outcomes, and operating more efficiently to keep costs down. A number of stakeholders (10%) mentioned that the medical centers would be reluctant to accept accountability for this guarantee if plan administration were moved to another division and they no longer had the same control or authority, which could then result in an increase to premiums and the overall cost of health benefits to the University.

The Benefits Program & Strategy Department within Systemwide Human Resources administers a number of the University's health plan options, including some self-funded plans. One reason cited by stakeholders (24%) to consider moving plan administration under Systemwide HR (Benefits) would be to have all plans under one portfolio so that they could be managed collectively to the best interest of the University and the employees. A number of stakeholders (12%) also cited the lack of a unified approach which has led to inefficiencies and turf wars between UC Health and Human Resources. UCOP leadership is aware of this and is working on ways to improve communication and cooperation between the two groups, which already has yielded significant benefits to the University in connection with the renewal of HealthNet's contract.

Stakeholders (29%) also expressed concern regarding a perceived conflict of interest in having a provider who seeks to maximize payers' contributions also manage a health plan that, ideally, should provide the maximum benefit at the lowest possible cost. In July 2016 outside counsel opined that there is no legal conflict of interest inherent in UC Care's operation by UC Health.[13] However, the perception of a conflict of interest still persists. To address these concerns, President Napolitano established an Executive Steering Committee on Health Benefits Programs in 2017 to govern the self-funded plans; this committee includes the following members; UC President (or designee), EVP & Chief Operating Officer, EVP UC Health Division, EVP & Chief Financial Officer, AVP and Chief Strategy Officer, Deputy General Counsel for Health Affairs & Technology Law, and an Academic Senate representative.[14] All are subject to the University's Conflict of Interest Code and regularly declare their conflicts.

Stakeholders also weighed in on the Huron suggestion of moving plan administration to Risk Services. Risk Services helped to launch the self-funded plans in 2014 and some stakeholders (14%) noted that they would be able to apply the same analytics to the self-funded plans that are applied to managing all other risk programs. However, it was also noted by some (22%) that perhaps the Risk Services division does not have the same experience managing employee health plans (including Medicare/retiree plans) as does UC Health or Human Resources.

STUDENT HEALTH & COUNSELING (CLINICAL OVERSIGHT)

Huron Options re: Location of Student Health & Counseling (including medical oversight of UC SHIP)	
a	Keep Student Health & Counseling within the UC Health Division at UCOP and/or move with the rest of the UC Health Division to a new "location".
b	Move Student Health & Counseling (including medical oversight of UC SHIP) from UC Health to the Student Affairs Department within the Academic Affairs Division at UCOP

In November 2012, Regent's Policy 3401[15] effectively shifted medical oversight of the Student Health and Counseling Centers (SHCs) from Student Affairs to UC Health. UC Health is also responsible for medical oversight of UC SHIP – this involves making clinical interpretations of medical and pharmaceutical utilization data, plan design and benefit structure, addressing patient appeals, and providing recommendations to the SHCs and UC SHIP based on these interpretations. Plan administration and financial oversight of UC SHIP currently resides in Risk Services and there is no proposal to move this function.

Given the positioning of Student Health and Counseling programs under Student Affairs on many UC campuses, Huron proposed that UCOP consider moving the clinical oversight function back to Student Affairs, including the medical oversight of UC SHIP. It should be noted that there has been movement among some UC academic medical centers towards integrating student health and counseling centers within the clinical operation of the medical centers.

[13] Appendix F - Executive Summary of Outside Counsel Opinion Letter Regarding Conflict of Interest Analysis of the UC Care and Blue and Gold Plans, August 23, 2016
[14] Delegated Authority 2610; https://policy.ucop.edu/_files/da/da2610.pdf
[15] http://regents.universityofcalifornia.edu/governance/policies/3401.html

In order to gain greater insight into the possible risks and benefits of this move, additional surveys regarding this particular option only were sent to all SHC and Counseling and Psychological Services (CAPS) Directors at all 10 campuses; 55% responded. Across all respondents combined, 40% felt that the expertise for health care clearly lies within the UC Health Division and that the consistent medical oversight provided by UC Health has improved the quality and safety of care and has decreased risk for staff and students alike. While 30% of all respondents commented that moving this function under Student Affairs would make sense given the alignment of student health and counseling under Academic Affairs on the campuses, 41% felt that student health is a care delivery service and that Student/Academic Affairs does not have the infrastructure needed to address clinical quality assurance, credentialing and/or interface with the medical establishment, which would expose the University to clinical care risk.

It is important to note that almost all (91%) of the 11 SHC and CAPS Directors who responded to the survey, cited equally both risks and benefits regarding the option to move this function under Student Affairs. There is a perception among this group (91%) that medical models have a different philosophical underpinning than campus counseling and psychological service centers, and that because UC Health represents the medical model, it lacks sufficient understanding of CAPS.

RECOMMENDATIONS

After reviewing the scope and impact of current operational challenges within UC Health along with careful consideration of stakeholder input with respect to various possible solutions, the Advisory Committee unanimously concluded that the following recommendations, if approved, could provide the UC Health Division office the increased agility and flexibility it needs to support the academic medical centers and health professional schools, while assuring transparency, minimizing risk and disruption, and maintaining the integrity of current structures of authority and decision-making across the UC system. It should be noted that even while this report was being drafted, the UCOP landscape was changing - a new recruiter with health care experience was hired, the FY18-19 OP budget was approved and the Major Projects and Initiatives Process threshold was increased. These changes partially address *some* of the challenges identified and outlined in this report and are reflected in the recommendations being forwarded for consideration below:

LOCATION & GOVERNANCE OF UC HEALTH DIVISION OFFICE

1. The UC Health Division should remain a division of UCOP.

2. To enable the University's health systems to further develop and expand, pay for, and execute strategies that will allow them to achieve collaboratively what they would otherwise be unable to achieve operating independently of one another, UC Health Division activities should be disaggregated into two distinct sub-divisions, each with its own operating budget.

    a. The first sub-division and associated budget would include all UC Health Division functions/activities that are funded by the UCOP core operating budget (state general funds) and by fees charged to the self-funded health plans.

    b. For purposes of this Report <u>only</u>, we have given the second sub-division a placeholder name to help convey its primary purpose: *The UC Healthcare Collaborative (UCHC).* The UCHC and its associated budget would include all UC Health Division functions/activities that are funded solely by the health systems via cost-transfer (the source of funds will be clinical revenues). As all expenses of this sub-division would be borne by the health systems, the Committee recommends that the President and the Regents exclude its operating budget and associated FTE from the growth limitations imposed upon other UCOP divisions to allow for the development and growth of essential collaborative programs and services. *(For those readers familiar with UCOP budgeting procedures, this sub-division would simply become a separate sub-line-item of the Heath Services Division budget, and recorded as such on Schedule D.*).

    c. Both sub-divisions should be positioned under the UC Health Division inside UCOP, reporting to the EVP to take full advantage of already existing governance and management infrastructure. The EVP for UC Health would continue to report to the President.

    d. Both sub-divisions, their currently funded activities and future investments should be guided by the UC Health Strategic Plan, which should be evaluated at least annually and updated if/as necessary with stakeholder input to ensure that the Plan remains responsive to the clinical, teaching and research missions of the University in a rapidly changing healthcare environment.

e. Both sub-divisions would continue to follow the same policies and processes that apply to all other UCOP divisions (except the budget and FTE exception noted in 2b). However, as is described in the report, there are substantive differences between managing/operating a university and managing/operating a healthcare delivery system. To provide the flexibility and agility that the health care enterprise will require in the coming years, UCOP leaders and staff should take these differences into account as UCOP polices and processes pertain to the UCHC.

3. No changes to existing governance. The UC Health Division of UCOP, the UC medical centers and health professional schools should continue to be governed by the Regents' Health Services Committee, and other Regental committees that currently oversee health related activities across the UC system. The Executive Vice President of UC Health should continue to report to the UC President.

4. No changes to existing structure. The UC health professional schools and medical centers should continue to be organizationally aligned with the campuses where they reside, with no changes to the current governance, management, reporting relationships, and authorities.

Improved Transparency and Accountability

5. To ensure transparency and accountability, the Executive Vice President for the UC Health Division of UCOP should provide briefings on the operating budget of the UC Health Division and the UCHC (including sources and uses of funds), as well as reports of progress regarding the UC Health Division Strategic Plan to the Health Services Committee of the Board of Regents, the Executive Budget Committee of UCOP, and the Council of Chancellors.

6. More frequent, structured, and systematic involvement of the chancellors in policy development, strategy formulation and funding decisions should be developed and implemented. By December of this year and annually thereafter, the EVP of UC Health should present the proposed budget for the UCHC to the chancellors of the six campuses with health systems for review and recommendations to the Executive Budget Committee who will then make recommendations to the President for approval. The EVP should also provide an overview of the components of UC Health's strategic plan relevant to the UCHC, and provide quarterly updates thereafter to coincide with Council of Chancellor meetings. For proposed projects and spending that arise off cycle, the EVP should also present items to these same chancellors for their review and recommendations to the President for approval.

7. To ensure the optimal internal structure and operational effectiveness within the UC Health Division office, the division should move forward as soon as possible with Goal #7 in their Strategic Plan – completing an organizational review and staffing plan that will outline needed positions and an effective recruiting and on-boarding timeline in order to best achieve the division's goals. The staffing plan should include a pro forma delineation of which FTEs will be funded by the first subdivision, and which will be funded by the second subdivision - the UC Healthcare Collaborative.

Improved Operational Effectiveness

8. Following a year of evaluation, to improve UCOP's ability to respond to market and stakeholder demands (including those of the UC Health Division), the President has modified the Major Projects and Initiatives (MPI) process to increase the threshold amount (per project or initiative) up to $300,000 from $100,000. The Advisory Committee recommends that after a specified trial period, UCOP evaluate the types and cost of projects and initiatives submitted by UC Health through the MPI process and if there are no fiscal control or operating issues of concern, consider raising the threshold. MPI threshold levels above $300,000 could be piloted and evaluated for the UC Health Division.

9. To address challenges associated with compensation, add specialized health-related responsibilities and/or qualifications to UCOP's library of job standards under Career Tracks. Until this is implemented, the Advisory Committee recommends that UC Health be allowed to utilize UCSF Career Tracks for similar UCOP positions.

10. To facilitate recruitment of professionals to the UC Health Division, OP Human Resources has just hired a dedicated health care recruiter. This new HR professional started in August 2018. No later than the end of June 2019, the EVP of UC Health and the COO of UCOP together should evaluate the effectiveness of this new OP HR recruiter and report their findings and conclusions to the President.

Self-Funded Health Plans

11. If the recommendation to keep UC Health within UCOP is accepted, the Advisory Committee recommends that UC Health should retain its current role in administration of the self-funded health plans. It is beyond the scope of the Committee's charge to evaluate the plan structure and offerings of University employee health benefits; the Committee nevertheless believes that a thorough evaluation of the University's approach to employee health benefits would be timely and important.

Student Health & Counseling

12. To maintain critical medical oversight of Student Health and Counseling, the Chief Medical Officer and the functions of this position for Student Health and Counseling should continue to report to the UC Health Division of UCOP.

13. To address reported concerns of leaders of campus-based Counseling and Psychological Services (CAPS) about growing student demand for their services and a perceived lack of a coordinated, strategic response, the Committee recommends "listening and learning sessions" facilitated jointly by UC Health and Student Affairs, to include Vice Chancellors of Student Affairs, Student Health & Counseling leaders, and other UCOP and campus leaders with a mandate to develop and implement a coordinated action plan that addresses concerns identified by the participants.

IMPLEMENTATION CONSIDERATIONS

While implementation is outside the scope of this review, it is recognized that implementation of any approved changes will require further administrative action and that additional decisions will need to be made around protocol, timing, processes and resources. The Advisory Committee would recommend that these decisions be made with systemwide input where possible and that all changes be in place by the beginning of the next fiscal year (FY19-20). The following is a list of recommended early implementation steps:

1. Define a clear process by which the existing UC Health Division operating budget will be disaggregated into two distinct subdivisions
2. Develop a staffing plan for UC Health Division open positions that encompasses both sub-divisions and is derived from the UC Health Division Strategic Plan
3. Add specialized health-related responsibilities and/or qualifications to UCOP's library of job standards under Career Tracks
4. Post and fill UC Health Division open positions
5. Convene systemwide Student Health and Counseling Directors for first "listening and learning" session and begin the development of strategies to address identified issues
6. Create and execute a staff and stakeholder communication plan regarding any approved changes

APPENDIX A: UC HEALTH RESTRUCTURING STAKEHOLDER SURVEY SUMMARY

A survey was sent to the UC Health stakeholder groups outlined below on June 6, 2018 to elicit input regarding perceived risks and benefits of each of the Huron options, questions and alternative suggestions. It is important to note that survey comments represent a **snapshot of perception** at a given point in time. Perception may or may not accurately represent reality; however, **perceptions drive behavior** and are, therefore, important to consider. A number of dominant themes emerged. Themes highlighted here are typically those where a comment, idea or point was made by at least **4 different people**. Theme/comments were only counted once per person and were not weighted for frequency or emotion.

Total Full Survey Responses Received: 49/67 (73%)
Total w/ Student Health & Counseling Directors: 60/87 (69%) (Sent questions for Student Health only)

Functions	Sent	Received
Chancellor	8	6
Medical Center CEO	6	4
Health Science Dean	17	12
Health Care Task Force	16	10
UCOP Administrative Function	12	9
UC Health Advisory Committee	8	8
Sub-Total	**67**	**49**
Stud. Health & Counsel/CAPS	20	11
Total	**87**	**60**

Locations	Sent	Received
UC Berkeley	5	3
UC Davis	10	7
UC Irvine	8	7
UCLA	12	8
UC Merced	4	3
UC Riverside	5	2
UC San Diego	9	4
UCSF	10	7
UC Santa Barbara	4	2
UC Santa Cruz	3	2
UCOP	15	13
Other	2	2
Total	**87**	**60**

COMMENT SUMMARY FOR OPTION GROUP 1: LOCATION OF UC HEALTH DIVISION OFFICE

	Deans n=12	Chnclr n=6	CEOs n=4	UCOP n=9	HCTF n=10	AC n=8	TOTAL N=49	*Option Group 1: Location of UC Health Division Office*
The UC Health Division remains within UCOP as it is currently								
								Benefits
1a	2	6	2	3	7	4	24	Maintaining current status will **keep the integrity of the administrative structure of UC**. Will keep the integrity of the admin structures of the campuses wherein the Chancellor is the CEO, and the reporting relationship of the Chancellor to the President, and that of the CEO of the hospital and VCHS to the Chancellor.
1a	3	1	1			1	6	**Maintaining close connection between research, treatment and academic programs**. …without reducing the academic mission to a mere afterthought in the business-focused health care environment.
1a	2		1		2		5	**Business as usual, which we know, and can anticipate.**
								Risks
1a	7	3	3	3	4	6	26	**Does not allow the Health Systems sufficient agility and nimbleness to compete** in the health care market.
1a	2	5			2	5	14	**Constrained by legislative scrutiny of UCOP.**
The UC Health Division becomes a standalone entity, or "location," within the UC System led by an Executive Vice President who reports to the President and is governed by a committee of interested stakeholders, including Chancellors. This new "location" would be separate administratively from UCOP.								
								Benefits
1b	5	2	2	3	3	4	19	**Increase in nimbleness, allowing UC Medical Centers to compete in health care market**. Provides the UC Health Division office with **flexibility, agility** – ability to respond to environmental pressures in an appropriate and timely fashion.
1b	1		1	1		3	6	**Greater synergies between campuses**; ability to speak with one collective voice. Increased ability to collaborate.
1b		2		1	1		4	**Mitigates political challenges of being on OP budget.**
1b	2		1			1	4	Reduces levels of management. Exec VP and medical group can make decisions. **Increases the effectiveness and efficiency of decision-making**.
								Risks
1b	9	2	2	1	4	3	21	**Separation of the clinical enterprise from the academic missions**
1b	2	6	1	1		5	16	A campus that has a health system will see **divided administration and governance structures**. **Compromise of Chancellor's authority** over medical schools and programs.
1b	3		2	2	6	2	15	**Loosening of accountability** - independence of UC Medical Centers from OP governance.
1b	3		1	3	2	1	10	Could be **unnecessary, costly** and add **another layer of bureaucracy.** Result in **duplication of efforts**

Respondent Key: Deans=Deans; Chnclr=Chancellors; CEOs=Medical Center CEOs; UCOP=OP Subject Matter Experts; HCTF=Health Care Task Force; AC=Advisory Committee

COMMENT SUMMARY FOR OPTION GROUP 2: FUNDING OF THE UC HEALTH DIVISION OFFICE

	Deans n=12	Chnclr n=6	CEOs n=4	UCOP n=9	HCTF n=10	AC n=8	TOTAL N=49	*Option Group 2: Funding for UC Health Division*
The UC Health Division or separate "location" continues to be funded by a combination of State General Funds/UCOP assessment and assessment to the clinical enterprise								
2a								***Benefits***
	3		1	1		2	7	Multiple funding mechanisms. **More conduits for funding**
	2			1	2	2	7	**Emphasizes integration of the academic and health system** entities in UC
				1	3	2	6	**Maintains budget relation to OP.** Continues the expectations that UC Health is working on behalf of the University rather than as an independent entity trying to maximize revenue without regard to University mission or goals.
	2	1	1		2		6	**Business as usual**
					1	3	4	Provides a **mechanism for accountability**
								Risks
	5	1	2	3	3	3	17	Budget may **be subject to whims of OP/State**. UCOP funding is insecure and unpredictable. **Volatility and restrictions**
The UC Health Division or separate "location" is funded by a separate assessment to the clinical enterprise only, which would be determined by a governance committee. This assessment would be in addition to other UCOP-related assessments to which the Academic Medical Centers currently contribute.								
2b								***Benefits***
	3	1	2	3	2	1	12	Could make budgeting decisions including hiring **independently of OP.** The UC Health Home Office might achieve a **greater degree of freedom** from the existing constraints
	2			1	1		4	If the work of UC Health is **primarily to benefit the clinical enterprise, then that's where the funding should come from**.
								Risks
	5			2	3	2	12	**Loss of partnerships and academic leadership benefits** that come from integration with university campuses. How could we ensure that the **connection and coordination between the academic and clinical** components of UC Health will be maintained?
	2		3	2	1		8	**Additional taxation on Medical Centers.** Would have to be vigilance and clear plan to avoid double taxation for the health systems with regard to OP or campus taxes
		2			1	2	5	This funding mechanism will lead to a further divide in the administration and governance of the medical enterprise. May **isolate the Chancellors authority** in being able to manage their campus financials.
	2					2	4	Might lead to **clinical enterprise setting all priorities**.

Respondent Key: Deans=Deans; Chnclr=Chancellors; CEOs=Medical Center CEOs; UCOP=OP Subject Matter Experts; HCTF=Health Care Task Force; AC=Advisory Committee

COMMENT SUMMARY FOR OPTION GROUP 3: LOCATION OF SELF-FUNDED HEALTH PLANS

	Deans n=12	Chnclr n=6	CEOs n=4	UCOP n=9	HCTF n=10	AC n=8	TOTAL N=49	*Option Group 3: Location of Self-Funded Health Programs*
Self-Funded Health Insurance Program/s remain within the UC Health Division at UCOP or moves with the rest of the UC Health Division to a new "location"								
								Benefits
	2	1		3	2	1	9	**Expertise** for health care and health care insurance **lies with Health Division**. UC Health's culture of innovation; support for becoming a market leader in how health benefits are delivered; small, talented, high-functioning team that has been able to rein in cost increases and deliver on promise to the President.
								Risks
3a			2	3	8	1	14	Perpetuates an unresolved inherent/perceived **conflict of interest**
	2		1	3			6	**Operational Challenges:** Risk that approach to benefits is **not a consistent, unified approach**; ongoing perception of **turf wars**. The inability of the teams in both divisions UC Health and Human Resources to smoothly collaborate on changes and enhancements to the programs; so, opportunities are slower to develop and launch. **Inefficiencies** in plan administration by having some **overlap in functions with HR**.
Self-Funded Health Insurance Program/s move to the Human Resources Department within the Chief Operating Officer Division at UCOP								
								Benefits
				6	5	1	12	Providing **benefits is the business of system-wide HR; Alignment of plans under a single umbrella** - all benefit vendor negotiations, management, and administration.
			1	1	6		8	**It would solve the conflict of interest question.**
								Risks
3b	2	1	1	2		2	8	HR professionals have many talents and important content expertise but employee health benefit design and execution has become a "content area" unto itself and **requires knowledge of health care delivery**, human behavioral economics, as well as, employee benefit design. **Expertise better positioned in UC Health.** No health expertise helping to run the program.
			2	1	1	1	5	UC Health **providers will be reluctant to accept accountability without the corresponding responsibility / authority** that comes with plans' residing within UC Health. Risk that **pricing / cost of health benefits** for the University **will rise**; premiums will escalate.
	2		1			1	4	**Too much uncertainty** with this approach. **Loss of control or input**.
Self-Funded Health Insurance Program/s move to the Risk Services Department within the Chief Financial Officer Division at UCOP								
								Benefits
3c	3			3		1	7	They will **apply same analytics to the self-funded health care plans that are applied to managing all other risk programs**. UC Care was built and launched in Risk Services, so there is some knowledge and expertise there; the Risk Services team is innovative and has been managing self-funded insurance programs since 1980 and has recently built, and designed their own insurance company, so, the willingness to be creative and think "out of the box" exists in risk
								Risks
		1		4	3	3	11	**Not sure the right type of expertise exists here**. Most of the risk products managed within Risk services are not accessed by the workforce in the same way as medical plans (including Medicare/retiree plans).

Respondent Key: Deans=Deans; Chnclr=Chancellors; CEOs=Medical Center CEOs; UCOP=OP Subject Matter Experts; HCTF=Health Care Task Force; AC=Advisory Committee

COMMENT SUMMARY FOR OPTION GROUP 4: LOCATION OF STUDENT HEALTH & COUNSELING (MEDICAL OVERSIGHT)

	Deans n=12	Chnclr n=6	CEOs n=4	UCOP n=9	HCTF n=10	SH/CDs n=11	AC n=8	TOTAL N=60	*Option Group 4: Location of Student Health & Counseling (including medical oversight for SHIP)*
Student Health & Counseling remains within the UC Health Division at UCOP or moves with the rest of the UC Health Division to a new "location"									
4a									***Benefits***
	2	1	1	6	2	10	2	24	**Expertise for health care lies here.** Facilitates appropriate and consistent **medical oversight**. **There is joint oversight now**; at the system wide level, we report to health services, at the Campus level we report to student affairs; this shared oversight has improved the quality of care, safety of care and decreased risk for our staff and for our students -this **provides checks and balances and expertise that we did not have before**.
				2		2	2	6	**Isn't broke; don't fix!**
									Risks
	1		1	3		10		15	**May not be adequately accountable / responsive to students.** Medical models are often driven by a **very different philosophical underpinning**. **Minimal knowledge of student counseling center services.**
Student Health & Counseling moves to the Student Affairs Department within the Academic Affairs Division at UCOP.									
4b									***Benefits***
	2		1	4	1	10		18	May address concerns about lack of **accountability to students**. Tied to academic enterprise. Makes sense given the **alignment of the campuses.** Gives Student Affairs more legitimacy to help lead and make decisions and policy regarding our Centers, and it will help with overall communication and function. Many of our **closest campus partners** (e.g., CARE, housing, cross-cultural center, student health) **are in Student Services/Affairs**.
									Risks
	2	2	3	7	1	9	1	25	Student Affairs **does not have content expertise in health services delivery.** Lacking the infrastructure to address things like clinical quality assurance, credentialing, interface w/medical establishment**. Would expose UC to all kinds of clinical care risk**.
	1			1		2		4	Could lead to **less continuity of care.**

Respondent Key: Deans=Deans; Chnclr=Chancellors; CEOs=Medical Center CEOs; UCOP=OP Subject Matter Experts; HCTF=Health Care Task Force; AC=Advisory Committee

STAKEHOLDER COMMENTS ON DRAFT RECOMMENDATIONS

The Advisory Committee's Report of Findings and Draft Recommendations was distributed to the same stakeholder groups that received the initial input survey. Eighteen responses were received from 33 individuals (a number of respondents replied jointly). Most of the concerns/issues raised about the draft recommendations mirrored those submitted regarding the Huron options. Stakeholder input was used to inform the revised recommendations in this report. Comment themes raised by two or more individuals are summarized below.

Stakeholder Group	Sent	Responded
COC	8	2
HSC Member/Advisor	9	1
Medical Center CEOs	6	2
Health Science Dean	18	2
HCTF	16	5
Vice Chancellors, Student Affairs	10	10
CAPS Directors	11	1
Student Health Directors	10	2
Executive Budget Committee	11	0
UCOP Administrator Functions	17	8
TOTAL	**116**	**33**

- 33/116 Respondents (28%)
- 22 Separate Responses (3 responses had two or more authors)
- 18 Responses w/ actual feedback (4 respondents indicated "no comment")

#	Comment Themes
Recommendation #1: UC Health Division Remains at UCOP	
2	**In addition**, could **develop networks of personnel based at the campuses** who could coordinate systemwide activities for UC Health and funded by a consortium of health system campuses
Recommendation #2: UC Health Care Collaborative	
3	Statement of **"revising" the [strategic plan] is too vague; should be specific timeframes** for review and stakeholder comments, in particular Academic Senate involvement.
3	How does UCHC assessment relate to the current campus assessment to support OP? Funding of UCHC would have to be carefully defined so as to **avoid double taxation of the campus health systems**
2	**Need to have a specific process** by which this expanded assessment would be decided, reviewed, and approved.
2	Would be appropriate to **set milestones** at certain numbers of FTEs or $ amounts at which interim evaluations by governing stakeholders would be triggered.
Recommendation #3: No Changes to Existing Governance	
4	**Agree**
Recommendation #4: No Changes to Existing Structure	
4	**Agree**
Recommendation #5 : Periodic Briefings & Greater Involvement of Chancellors	
3	Should **include agency of Academic Senate**
3	**Agree**; critical recommendation. Wise recommendation
2	Statement on "periodic briefings" too vague; **should be a set timeline**, including comments from stakeholders
Recommendation #6 : Move Forward with UC Health Division Org. Review and Staffing Plan	
2	**Agree**
2	Should **include agency of Academic Senate**.
Recommendation #7: Core Operating/SFHP funded Activities Remain As-Is under UC Health at UCOP	
2	Recommend the **hybrid model** where the governance structure stays the same but UC Health is exempt from budget, FTE headcount and compensation limitations of UCOP and that this should also be extended to the UC campus health systems.
Recommendation #8: MPI Process	
3	**Agree**
Recommendation #9: Add Health Care Career Tracks at UCOP	
2	**Agree**
2	**There are university wide challenges with compensation** and it isn't entirely clear as outlined in the report that they are particularly more severe or significant than in other parts of the university.
Recommendation #10: Dedicated Health Care Recruiter	
2	**Agree**

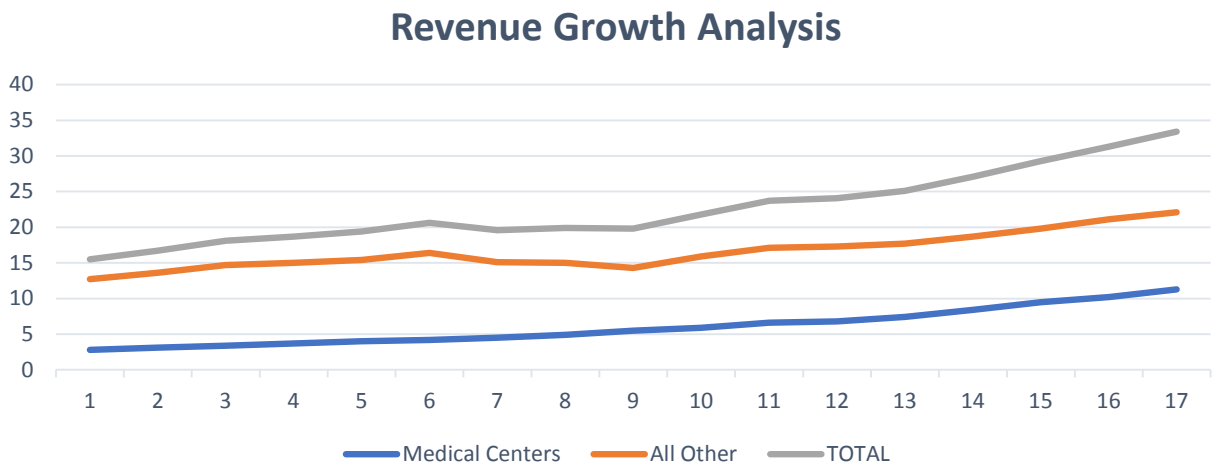
Recommendation #11: Location of Self-Funded Health Plans	
5	**Conflict of interest**
2	**Executive Steering Committee** does not have sufficient **Academic Senate representation and oversight**
2	**Agree**
Recommendation #12: Location of Student Health & Counseling (Medical Oversight)	
11	**Oversight Should Move to Student Affairs** The misalignment between the UC Health leadership's direction and decision making and the mission, values, and practice model within the SHCS on the campuses is administratively counterproductive and has the potential to compromise the quality of service provided to UC students [Note: ten of these respondents were represented in a single letter from the Vice Chancellors of Student Affairs]
4	**Agree**
Recommendation #13: Listen & Learn Sessions to Develop & Implement CAPS Action Plan	
2	**Student Health Directors must be included** in these listen and learn meetings to make sure the plans developed are inclusive.
2	**Agree**; CAPS Directors are in favor of this recommendation and are hopeful this can be a new vehicle for communicating our mutual concerns and for developing strategies that can be rapidly implemented
General Comments	
4	**No Comment**
4	**Agree**; report is balanced; appears to address needs; excellent report, nice job coming to good conclusions and a path forward
2	**Lack of Academic Senate oversight** in UC Health

APPENDIX B: UNIVERSITY OF CALIFORNIA REVENUE GROWTH ANALYSIS

2001-2017 MEDICAL CENTER VS. ALL OTHER REVENUE GROWTH

	2001	*2002*	*2003*	*2004*	*2005*	*2006*	*2007*	*2008*	*2009*	*2010*	*2011*	*2012*	*2013*	*2014*	*2015*	*2016*	*2017*	*Compound Annual Growth Rate*
Medical Centers	*2.8*	*3.1*	*3.4*	*3.7*	*4*	*4.2*	*4.5*	*4.9*	*5.5*	*5.9*	*6.6*	*6.8*	*7.4*	*8.4*	*9.5*	*10.2*	*11.3*	*9%*
All Other	*12.7*	*13.6*	*14.7*	*15*	*15.4*	*16.4*	*15.1*	*15*	*14.3*	*15.9*	*17.1*	*17.3*	*17.7*	*18.7*	*19.8*	*21.1*	*22.1*	*4%*
TOTAL	*15.5*	*16.7*	*18.1*	*18.7*	*19.4*	*20.6*	*19.6*	*19.9*	*19.8*	*21.8*	*23.7*	*24.1*	*25.1*	*27.1*	*29.3*	*31.3*	*33.4*	*5%*

Source: https://www.universityofcalifornia.edu/infocenter/revenue-and-expense-data



Appendix C: University of California Full-Time Equivalent (FTE) Growth Analysis

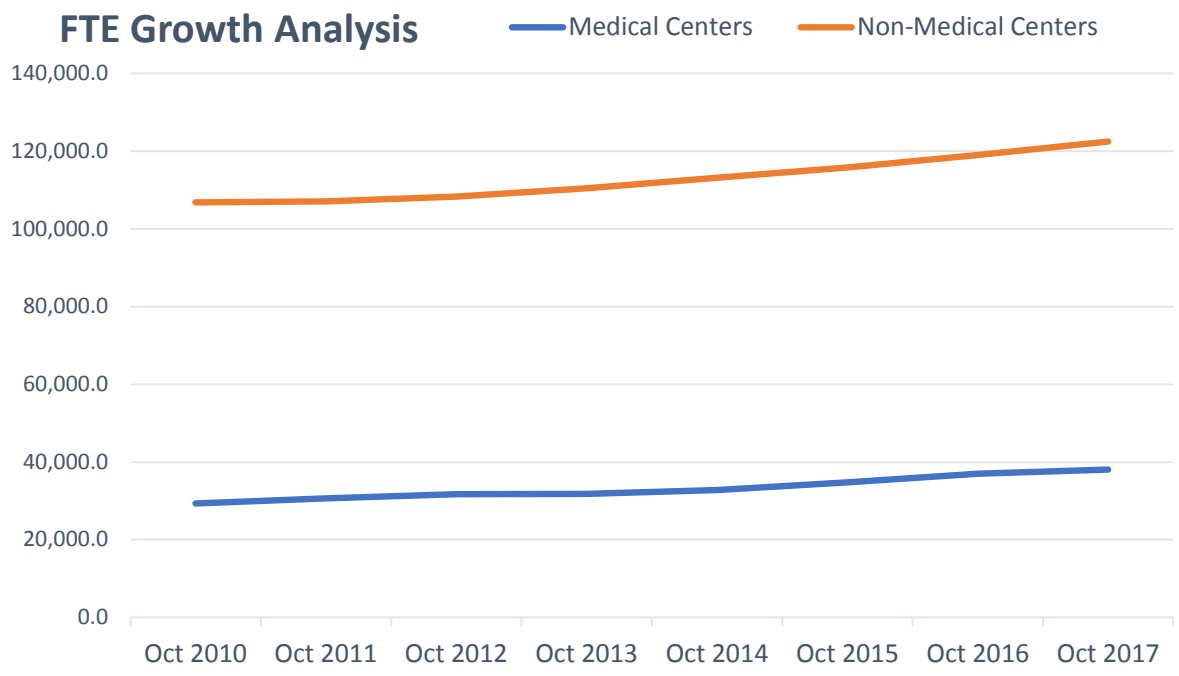
2010-2017 Medical Center vs. Non-Medical Center FTE Growth

FTE employees	***Oct 2010***	***Oct 2011***	***Oct 2012***	***Oct 2013***	***Oct 2014***	***Oct 2015***	***Oct 2016***	***Oct 2017***
Medical Centers	*29,349.6*	*30,621.1*	*31,755.4*	*31,835.1*	*32,791.5*	*34,774.7*	*36,962.5*	*38,050.3*
Non-Medical Centers	*106,820.7*	*107,050.6*	*108,331.2*	*110,461.8*	*113,197.8*	*115,802.8*	*119,047.1*	*122,524.4*
Total	*136,170.3*	*137,671.7*	*140,086.6*	*142,296.9*	*145,989.3*	*150,577.5*	*156,009.6*	*160,574.7*
	21.6%	*22.2%*	*22.7%*	*22.4%*	*22.5%*	*23.1%*	*23.7%*	*23.7%*

Source: https://www.universityofcalifornia.edu/infocenter/employee-fte

Compound Annual Growth Rate 2010-17

Medical Centers	*3.8%*
All Other	*2.0%*
Total	*2.4%*



APPENDIX D: UC HEALTH STRATEGIC PLAN STAKEHOLDER NEEDS & GOALS

The following needs surfaced through the UC Health Strategic Planning stakeholder pre-planning survey that was sent to 51 campus stakeholders (53% responded) in June 2017. These needs were articulated in response to the following two questions:

A. What 3-5 things could the office of UC Health do to help your organization be successful in advancing your priorities?

B. How and in what additional areas could UC Health facilitate the concept of "systemness" – such that together, the components of UC Health become greater than the sum of our parts?

UC Health Strategic Plan goals were then developed to support stakeholder requests:

1. Facilitate Collaboration
   - Academic to Clinic/Medical Center Partnerships
   - Education Partnerships (campus/disciplines)
   - Multi-Campus Research Initiatives
2. Support Systemwide Buying and Contract Negotiations
   - Value for Scale
3. Share/Scale Best Practices
   - Publish, Convene, Distribute
   - Benchmark
   - Develop and Distribute System Dashboards
4. Advocacy
   - State & Federal Government
   - Philanthropic/Donors
   - UCOP
5. Leverage Data/Technology to Support Initiatives in Care
   - Health Data
   - Business Intelligence
   - Telemedicine
6. Growth of a Viable UC Employee Health Plan
7. Explore Concept of Regionalization
   - By areas of specialization
   - By geographic region (e.g., North/South)

Position Type (Locations Received)	Surveys Received	Surveys Sent	Response Rate	% of All Responses Received
Health Sciences School Dean (B, D, I, LA, R, SD, SF)	13	17	76%	48%
Chancellor (M, R, SB, SC, SF)	5	10	50%	19%
Medical Center Chief Executive Officer (D, LA[1], R[2], SD)	4	7	57%	15%
Chief Medical Officer (D, SD)	2	6	33%	7%
Chief Nursing Officer (LA, SD)	2	5	40%	7%
Chief Financial Officer (D)	1	5	20%	4%
HCTF Chair, Academic Senate	0	1	0%	0%
Total	**27**	**51**	**53%**	

Notes:
[1] J. Spizzo and J. Mazziota (UCLA) submitted a joint survey; they were only counted as one.
[2] D. Deas (UCR) self-identified as a dean; but she is also the CEO. Her comments were counted in the CEO group. The numbers/percentages above reflect that change.

The following goals were developed in response to the above stakeholder needs:

Goal #	UC Health Division 2017-2022 Strategic Plan Goals
1	**Enhance LSfV Program:** Achieve at least $500 million/year in cost reduction/revenue generation starting in FY18-19 through improved system operational effectiveness by implementing new Leveraging Scale for Value (LSfV) initiatives and a new organization/governance for LSfV
2	**Facilitate Systemwide Strategic Planning:** To inform and enhance strategic decision making and avoid conflicting and/or redundant efforts, UC Health will provide leadership and support for campuses to collectively prioritize and advance targeted systemwide and regional transactions and initiatives beginning in January 2018
3	**Improve Quality and Outcomes; Lower Cost:** Advance the quality and efficiency of care delivery, improve patient outcomes, and reduce costs by providing leadership and support on the development and implementation of a data-driven system-wide quality and population health management function beginning in January 2018
4	**Improve UC Health Financial Management:** Develop a standardized infrastructure necessary to make accurate financial decisions and enhance successful business practices by December 2018
5	**Leverage Systemwide Data to Optimize Performance:** Collect and analyze data at a system level and use it to advance science, inform and improve operations, and generate efficiencies through economies of scale (and ultimately, savings) by establishing a new function / center within UC Health for system-level data-driven insights, innovation and transformation by March 2018
6	**Offer Compelling UC Health Plans:** Make UC branded health plans the clear choice for employees and their families, retirees, UC students and other employers beginning with open enrollment in 2020 by offering innovative, differentiated, compelling, affordable and comprehensive health plans with outstanding member experience
7	**Strengthen UC Health Internal Effectiveness:** To optimize our operational effectiveness and drive achievement of our strategic planning goals, conduct an independent organizational review of our office and implement resulting plan of action by December 2018
8	**Develop Systemwide Enrollment Plan & Strategy:** Improve alignment of the future size and scope of UC health sciences programs with state workforce/emerging health needs by developing a new system-wide health professions enrollment plan and strategy by October 2019
9	**Advance Progress in Promoting Diversity & Inclusion:** Support each UC health professional school in its efforts to improve diversity and campus climate for all UC health professional students, faculty, residents/fellows, staff, and administrative leaders by sharing strategies that have proven effective in the health sciences by June 2019
10	**Advance Interprofessional Health Sciences Education:** In partnership with campuses, facilitate discussion and information-sharing to leverage and advance health sciences professional education programs, and by December 2019, help campuses identify actionable, forward-looking goals that support campus-led partnerships to enhance interprofessional health sciences education across the system
11	**More Effectively Influence Public Policy as a System:** Engage proactively and strategically regarding important health-related legislative and regulatory activity, and systematically inform the campuses of pending activity and engage them in development of policy positions via a public policy function to be established within UC Health by December 2018
12	**Develop UC Health Leadership Program:** Develop a career development/leadership program in conjunction with UC School/s of Business for “high potential” individuals among the UC Medical Center and UC Health Office staff that allows them to advance their careers and remain within the UC Health System by September 2020

APPENDIX E: UC HEALTH STRATEGIC PLAN FTE REQUIREMENTS

This table illustrates the approximate number of new positions needed to successfully implement/execute the key strategies listed under each goal of the UC Health Division 2017-2022 Strategic Plan. Note: approximately 50% of these new positions would be located on the campuses. Estimated funding sources for these positions are also listed.

Division:	UC Health		PROJECTED FISCAL YEARS						
Date:	11/13/2017		FY17-18	FY18-19	FY19-20	FY20-21	FY21-22	FUNCTIONS	FUNDING SOURCE
ESTIMATED NEW FTE LOCATED at UCOP TO SUPPORT THIS GOAL									
Owner	**Goal #**	**Goal Topic**							
Williard	1	Enhance LSfV Program	-	-	-	-	-		
Engel	2	Facilitate Systemwide Strategic Planning	-	3	-	-	-	2 Project Managers 1 Market Analyst	Core Funds
Engel	3	Improve Quality and Outcomes; Lower Cost	-	3	-	-	-	1 Physician Leader 1 Qual/Pop. Health SME 1 Project Manager	Medical Centers (evolved CHQI)
Dias	4	Improve UC Health Financial Management	-	2	-	-	-	1 CFO .5 Analyst .5 Exec. Asst.	Core Funds
Engel	5	Leverage Systemwide Data to Optimize Performance	-	3	2	-	-	1 Sr.Bus Dev Analyst/Project Manager 1 Mid-level Bus Dev Analyst/Project Manager 1 Sr. Internal Strategy Analyst/Project Manager 1 Mid-level Internal Strategy Analyst/Project Manager 1 Data Governance Project Manager/Analyst)	Medical Centers (evolved CHQI)
Tauber	6	Offer Compelling UC Health Plans	-	-	2	1	-	1 Director 1 Manager 1 Analyst	Health Plan Premiums
Engel	7	Strengthen UC Health Internal Effectiveness	-	-	-	-	-	-	N/A
Nation	8	Develop Systemwide Enrollment Plan & Strategy	-	-	-	-	-	-	N/A
Nation	9	Advance Progress in Promoting Diversity & Inclusion	-	-	-	-	-	-	N/A
Nation	10	Advance Interprofessional Health Sciences Education	-	-	-	-	-	-	N/A
Engel	11	More Effectively Influence Public Policy as a System	-	4	-	-	-	1 State Policy Director 1 Policy Analyst 1 Federal Policy Director 1 Federal Policy Analyst	Core Funds
Stobo	12	Develop UC Health Leadership Program	-	1	-	-	-	1 Project Manager	Core Funds
TOTALS			**0.0**	**16.0**	**4.0**	**1.0**	**0.0**		
ESTIMATED NEW FTE LOCATED AT ALL CAMPUSES/LOCATIONS COMBINED TO SUPPORT THIS GOAL									
Owner	**Goal #**	**Goal Topic**							
Williard	1	Enhance LSfV Program	-	-	11	-	-	5 Project Managers 5 Analysts 1 Admin Support	Medical Centers (LSfV)
Engel	2	Facilitate Systemwide Strategic Planning	-	-	-	-	-	-	
Engel	3	Improve Quality and Outcomes; Lower Cost	-	-	-	-	-	-	
Dias	4	Improve UC Health Financial Management	-	-	-	-	-	-	
Engel	5	Leverage Systemwide Data to Optimize Performance	-	10.5	4	-	-	Yr 1=4 Engineers; Yr 2=+2 Engineers 1 Data Scientist Manager Yr 1=4 Data Scientists; Yr 2=+2 Data Scientists 1 Product Manager .5 Chief Health Data Officer	Campuses (evolved CHQI)
Tauber	6	Offer Compelling UC Health Plans	-	-	-	-	-	-	N/A
Engel	7	Strengthen UC Health Internal Effectiveness	-	-	-	-	-	-	N/A
Nation	8	Develop Systemwide Enrollment Plan & Strategy	-	-	-	-	-	-	N/A
Nation	9	Advance Progress in Promoting Diversity & Inclusion	-	-	-	-	-	-	N/A
Nation	10	Advance UC's Interprofessional Health Sciences Education	-	-	-	-	-	-	N/A
Engel	11	More Effectively Influence Public Policy as a System	-	-	-	-	-	-	N/A
Stobo	12	Develop UC Health Leadership Program	-	-	-	-	-	-	N/A
TOTALS			**0.0**	**10.5**	**15.0**	**0.0**	**0.0**		

APPENDIX F: OPINION RE: CONFLICT OF INTEREST W/ SELF-FUNDED PLANS

August 23, 2016

Executive Summary of Outside Counsel Opinion Letter Regarding Conflict of Interest Analysis of the UC Care and Blue and Gold Plans

The University of California ("University") asked an expert outside attorney ("Counsel") to determine whether the current structure and planned oversight changes to the UC Care and Blue and Gold plans violate regulatory requirements for employer sponsored health benefit plans, state and federal antitrust laws, and/or the Political Reform Act. Counsel was also asked to provide recommendations for ensuring proper compliance with applicable laws and conflict concerns.

In sum, following analysis of the relevant documents and discussions with key stakeholders, Counsel concluded that there has been no violation of applicable state or federal law. As UC Health moves toward a more complete management of the UC Care and Blue and Gold plans, Counsel provided several recommendations to avoid any potential conflicts of interest, discussed herein.

Key Factual Underpinnings Related to the Opinion

- The Blue and Gold plan has many similarities to the UC Care plan in that much of the insurance risk resides with the University.[1]

- The UC Care plan is unique from other self-funded PPO plans in that it has a three-tiered benefit structure, and is not subject to state or federal regulatory oversight.

- With a fully-licensed health plan third-party administrator ("TPA") (currently Blue Shield of California, but soon to be Anthem Blue Cross) assuming fiduciary responsibility over all administrative functions, there is a clear separation between the University and the TPA's roles with respect to the UC Care plan. This separation demonstrates that the UC Care plan has appropriate safeguards to ensure fair and impartial interpretation and coverage determination of UC Care plan benefits.

    - While the UC Care plan is not subject to ERISA, it mimics the structure and administration of ERISA plans.
    - This is important, because under ERISA, if a plan retains *both* benefit determination and funding authority—and does not separate the two functions by using an independent administrator—then a conflict of interest is assumed and benefit determinations are subject to strict judicial review.

- UC Care is exempt from the regulatory oversight of the two insurance regulators in California under the Insurance Code and the Knox-Keene Act, because it is a self-funded plan of a public employer.

[1] UC Health notes that this risk is borne primarily by the University's health systems, rather than the University's health benefits plans: UC Health has committed to a cap on premium increases of 5% annually but assumed a substantial portion of the financial risk associated with costs of care provided to Blue & Gold members who obtain their care through UC Health providers, and some risk for the costs of care provided to Blue & Gold members who obtain their care elsewhere.

- UC Health previously committed to the Office of the President for UC Care and Blue and Gold plans that the premiums paid by the University for these plans will not increase more than five percent per year.[2]

- UCHR should continue to ensure that all the plans are fairly and equitably funded with University and employee contributions and that no health programs are disproportionately funded to the detriment of the other health insurance options offered by the University to its employees and their dependents.[3]

- Many of the key managers within UC Health have compensation packages that are tied to the financial performance of the UC Health enterprise.[4] This potentially creates an incentive for UC Health managers to increase payment rates from *all* payors (including the University with respect to UC Care) so that UC Health is more profitable and UC Health leadership receives greater pay.

- In order to make the plan affordable for University employees, retirees, and their dependents, UC Health has a direct interest in how the University funds health benefits provided to enrollees of the UC Care plan.

- UC Health expects to assume a leadership role by controlling the budgets for both UC Care and the Blue and Gold plans. UCHR will continue to determine what benefits are offered, while UC Health will price the plans.

- As the University becomes more self-insured, different skill sets will be required.

Legal Opinion

UC Health's financial involvement and day-to-day management of UC Care and the Blue and Gold Plan do not violate state or federal Antitrust Laws or the Unfair Business Practices Act or the Political Reform Act.

Recommendations to Avoid Conflicts of Interest

Both UCHR and UC Health have important roles in ensuring the viability and breadth of health benefit options available to University employees, retirees, and their dependents.

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[2] More recently, UC Health committed that, beginning with the 2019 plan year, *any* premium increases will be subject to approval of the President.

[3] UC Health understands that different health plan options have been treated differentially for many years, prior to the existence of UC Care and certainly prior to UC Health's management of any health plans. An alternative option is to assure that UC Health does not control decisions over premium contributions.

[4] UC Health notes that: (i) financial performance is not the only measure that determines incentive compensation; (ii) short-term and long-term CEMRP goals are approved annually by an Administrative Oversight Committee comprised of the Executive Vice President – Chief Operating Officer, the Vice President – Human Resources, the Executive Director – Compensation Programs and Strategy, and the Chancellors of each campus with a health system; and (iii) all systemwide performance objectives are approved by the President. See http://policy.ucop.edu/files/smg-docs/smg_cemrp.pdf.

Without proper controls in place, a potential conflict of interest could arise if UC Health were to assume full responsibility for: (1) setting or determining premiums paid by the University for employees, retirees, and their dependents enrolled in either the UC Care or Blue and Gold plans; or (2) developing the benefit structure of either the UC Care or Blue and Gold plans, due to the structure of current bonus incentives. However, UC Health has an important role in evolving how healthcare services are efficiently and cost-effectively delivered within a coordinated managed care environment. Integration through ACOs is proving to be an effective tool in controlling costs and maintaining quality of healthcare services. Both UC Care and the Blue and Gold plans offer great opportunities for the University to take advantage of these changes. In order for UC Health to succeed in developing cost effective ACO models, it needs to be included in all aspects of the plan operations, including discussions regarding funding and benefit design.

In order to ensure that UCHR and UC Health are able to meet their respective obligations and goals, while avoiding the appearance of a conflict of interest, Counsel offered the following suggestions. Each is followed below by a note briefly describing the University's response.

1. Governance

Expert Recommendation: Most of the potential conflicts (real or apparent) could be eliminated if the University established a robust steering committee to oversee significant issues concerning either the UC Care or the Blue and Gold plan. If the committee is authorized to make financial decisions concerning the two health plans, then concerns over individual conflicts of interest would be eliminated. Such a committee would likely consist of representatives of both UC Health and UCHR. Additional individuals knowledgeable in health plan governance and law should certainly be included on any such committee.

University Response: The President has directed that a Joint Operating Committee and an Executive Steering Committee be established to facilitate the collaboration and oversight needed to transparently and effectively operate and govern the health plans. The Executive Steering Committee will be comprised of:

- the Executive Vice President – Chief Financial Officer
- the Executive Vice President – Chief Operating Officer
- the Executive Vice President – UC Health
- an advisory member of the Regents Health Services Committee appointed by the President from among two nominated by the Executive Vice President – UC Health
- a faculty member of the Senate Task Force on the Future of UC Health Care Plans appointed by the President from among three nominated by the Task Force
- the Deputy General Counsel – Health Law and Medical Center Services (non-voting, serving as legal counsel)

The first order of business for the JOC and ESC will be to develop and approve a Memorandum of Understanding addressing the relative roles of different stakeholders in the operation and oversight of the University's health plans.

2. Financial Matters

Recommendations: The University could take one of the two following courses of action:

a. Realign compensation for UC Health managers and executives so that their compensation is not tied to the financial performance of the UC Health system, ***or***
b. Implement all of the following controls:
    i. UC Health should participate in, but not control, how the University sets premiums and employee contributions for the UC Care and Blue and Gold plans.
    ii. UC Health should participate in, but not control, benefit structure or design for either the UC Care or Blue and Gold plan.
    iii. Consider paying UC medical facilities at a rate tied to Medicare and not to a commercial health insurer contract.

University Response: The following controls will be recommended for inclusion in the MOU: (1) a requirement that CEMRP goals exclude from consideration the financial performance of the University's employee and retiree health plans, as well as revenues and losses associated with the provision of health care services to beneficiaries of those health plans; and (2) language vesting control of benefit design and establishment of premiums and employee contributions for all University health plans, whether self-funded or shared risk or fully insured, with Human Resources and Benefits. UC Health will continue, subject to a cap on annual increases approved by the President, tying rates offered to the University's self- funded health plans to the University's lowest-price commercial contract (currently Anthem), and believes that this, together with other controls described above and below, will adequately address the concerns driving this recommendation.

Separation of Functions

Recommendation: Individuals at UCOP who are not affiliated with UC Health should co-sign internal agreements and MOUs between UCOP and UC Health related to UC Health's provision of services to the University's self-funded and shared risk health benefits programs and their enrollees.

University Response: The University will ensure that the President or her designee (not affiliated with UC Health) signs all such agreements; the Executive Vice President – UC Health or his designee and the Chancellors or their designees will continue to sign agreements between the University's clinical enterprise and its payers on behalf of UC Health. Formal Delegations of Authority will be amended accordingly, as necessary.

Additional Controls

University-Initiated Control (not addressed by the expert): The ESC will serve as fiduciary of the health plans to reflect and reinforce the ESC's oversight responsibilities.