Executive Summary of 2008 (Second) UPI Bylaws Revisions

Purpose of Revisions. The circumstances which precipitated the need to revise the UPI Bylaws include:

1. The need to modify the language in the UPI Bylaws to make them consistent with the actual common practices and terminology that UPI has adopted over the past decade;

2. The need to include rules that accommodate the inclusion of affiliate hospital members on the UPI Board of Directors, as well as UPI representation on the TCH Board; and

3. The desire to create a Clinical Enrichment Fund to reinvest in new clinical programs.

Process for Amending the UPI Bylaws. These proposed changes to the UPI Bylaws were drafted by a subcommittee of UPI. The committee membership is listed in Attachment A. These proposed changes were then submitted to the UPI Board of Directors for approval. The UPI Board of Directors approved these proposed changes on April 15, 2008 by a vote of 22 in favor, 0 (zero) opposed and 0 (zero) abstentions. Pursuant to the UPI Bylaws, in order for these proposed changes to be implemented, they must also be approved by a majority of the UPI members who vote on the proposed amendments. If approved, these proposed changes will go into effect on September 15, 2008.

Material Modifications and Additions. The following is a summary and explanation for the proposed material changes to the UPI Bylaws. In addition to the changes outlined in this executive summary, there are a number of minor, cosmetic changes. The material proposed changes are as follows:

1. Modification to Article I, Section 2(c), "Purposes and Objectives". The stated "purpose and objective" of UPI in providing assistance to the SOM in its providing indigent care was removed given the significant cuts in federal funding. Furtherance of charitable activities was left in Section 2(a) and was thought to incorporate indigent care without being so specific and, possibly obligating UPI to provide an unsustainable level of unreimbursed care.

2. Addition of Article VI, Section 1(h), "Termination of Membership". The following condition for termination of membership was added for consistency with the current inclusion of such phraseology in all letters of offer:

> "if the individual's hospital privileges, at a hospital where he/she performs the majority of her/his duties, are revoked or suspended, so as to materially affect her/his ability to practice medicine at that facility"

3. Addition of Article VII, Section 5, "Representatives of Affiliate Hospitals on the UPI Board of Directors". A new provision was added to allow for representatives

from the affiliate hospitals, such as TCH and UCH, to become voting members of the UPI Board of Directors. This addition was prompted by the completion of an affiliation agreement between TCH and the SOM which provides that UPI will have representation on the TCH Board of Directors and that, in return, UPI will permit TCH representation on the UPI Board of Directors. In order for this to occur, a 2/3 majority vote of the UPI Board of Directors is required. Furthermore, non-UPI "community physicians" may not be the affiliate hospital representative as this may create a conflict.[1] There is also a process for arriving at who the UPI member will be for an affiliated hospital (only TCH for now) Board of Directors.[2]

4. Deletion of Article IX, Section 7, "Medical Director as UPI Officer". To keep the Medical Director's activities from being interpreted as UPI itself practicing medicine, the Medical Director position has been removed from the Officers section and will instead be a faculty member who reports to the Dean of the SOM. This action is necessary for protection of government immunity in malpractice cases.

5. Modification of UPI's Funds (Article X) and Academic Enrichment Fund (Article XI). Some of the most substantive modifications to the UPI Bylaws have taken place in these two sections and should, therefore, be reviewed carefully prior to voting. In order for the Bylaws to reflect actual current practice, changes were made to Article X..

Specifically, for several years, UPI has assessed AEF taxes on a more limited amount of revenue than is allowed by the current Bylaws. By practice administrative service and salary support contracts have been excluded from taxation as have certain approved facility fee revenue. The Bylaws have been rewritten to define and formally exclude these revenues from AEF taxation.

6. Addition of Article XI, Sections 4 and 5, "Creation of a Clinical Enrichment Fund (CAEF)". As noted in #5 above, the current Bylaws apply the 10% AEF to all revenue. The addition of Article XI, Sections 4 and 5, creates a new clinical Enrichment Fund which would be funded by a 5% tax on certain "investment" income instead of the current 10%. Additionally, these funds would not flow into the existing AEF which is allocated primarily for academic (Research and Education) program support. This fund will allow UPI to collectively invest in the clinical enterprise in the same way that the Dean uses AEF funds to invest in the academic enterprise. The Bylaws Committee discussed concerns that (1) the CAEF would divert funds away from the highly successful AEF program; (2) the existence of a UPI CAEF might cause the affiliated hospitals to provide less support for clinical programs; and, (3) how would UPI decide which new programs to support and to what degree. The revised UPI Bylaws address all of these issues by (1) identifying a new "non-clinical" source of funding that has not yet fed into the "AEF stream"; (2) explicitly stating in the Bylaws that these funds are not to replace or offset hospital support; and, (3) providing for a faculty committee, much like the SIRC (Strategic Initiative Research Committee) function with AEF, that would review proposals and advise UPI Board of Directors on funding options, which would maintain control of the funds. [3]

7. Modification of Article XII, "Medical and Consulting Revenue". This section was modified to accurately reflect the rules as outlined in the Member Practice Agreement and the fact that "out of department" work comes from much more than just medical/legal activities. The term "consulting" has been clarified in the UPI Bylaws along with a broad definition (specifics will continue to be delineated in the Member Practice Agreement). [4]

8. Modifications to Article XIV, "Cost Center Incentive Plans".

a. Section 1, "Incentive Plan Review". Mandatory departmental review of incentive plans has been extended from every three years to every five years.

b. Section (2)(f), "Cost Center Incentive Plans, Mandatory Reserve Funds". These changes corrected an error made in the 1998 revision. A long-standing rule is that departments must maintain a reserve at least as great as 10% of annual UPI salaries in a reserve account. The intent of the 1998 bylaws committee (as evidenced by their minutes) was to require departments in "arrears" of the 10% requirement to first put all of their overage towards the reserve before paying out incentives to members. What was actually written and passed in 1998 was that only 10% of the overage needed to be applied towards correction of a reserve deficit. This in effect created a situation in which a department would never actually get to their reserve requirement. In 2006 the UPI Board confirmed the original intent and passed a Board resolution to clarify and reinforce the reserve requirement but allow departments with deficit reserves to allocate 50% of any improvement to their incentive plan formula and 50% to the reserve until the minimum reserve balance is reestablished.

c. Section 2 (i), "Cap on Incentive Distributions". Historically, UPI Bylaws have limited the maximum incentive faculty may receive to 100% of their base and supplement University salary. This revision to the Bylaws lifts that ceiling and incentives can now exceed 100% of the Base plus Supplement as long as total compensation does not exceed reasonable fair market compensation -- needed for tax exempt status).

APPENDIX

[1] "**UPI Board Members who are Representatives of Affiliate Hospitals**. Upon a 2/3 vote of the voting members of the UPI Board of Directors and subject to the terms of any formal agreement between UPI and an Affiliate Hospital, UPI may permit one or more representatives from Affiliate Hospitals, in an amount determined by the UPI Board of Directors, to become voting members of the UPI Board of Directors. The selection of the individuals to serve as the Affiliate Hospital representative on the UPI Board of Directors shall be left to the discretion of the Affiliate Hospital, however, that representative, if a physician, must be a UPI Member. Subject to the terms of any affiliation agreement between an Affiliate Hospital and UPI, Affiliate Hospital Board members of the UPI Board of Directors may be removed at any time and for any reason upon a 2/3 vote of the UPI Board of Directors." Affiliate Hospital representatives serving on the UPI Board shall be voting members, but may participate in Executive Sessions of the Board only with the explicit approval of the President of UPI.

[2] "**UPI Representation on Affiliated Hospital Board of Directors**. Subject to the terms of any affiliation agreement between an Affiliate Hospital and UPI that permits UPI representation as a member of the Affiliate Hospital Board, selection of this representative shall be made upon a vote of the UPI Board of Directors from a slate recommended by the UPI Executive Committee."

[3] **Section 4. AEF Assessment on Investment Income and Non-Professional Services.** Income generated from Non-Professional Services will be subject to a 5% tax which will be used to form a Clinical Academic Enrichment Fund (CAEF), which shall be managed consistent with the terms set forth in Section 5 below.

This category of income represented revenue that is not generated by the professional clinical and consulting services of individual faculty (as defined in Article XI, Section 2 above). It is revenue generated by UPI corporate, departmental or divisional activities, investments and equity ownership. For purposes of CAEF taxation, UPI income earned from non-professional activities, investments and equity ownership activities shall mean all monies received in excess of any 1) initial cash contributions used to invest in the activity, and 2) subsequent cash call contributions, and 3) federal and state income taxes assessed on those earnings. This income includes, but is not limited to income generated from ownership in corporate, LLC, or partnership join ventures whereby profit distributions and/or dividends are received. Interest income which is earned on clinical and administrative operating cash and on cash equivalent reserves held by departments or UPI corporate accounts, and that are invested according to UPI's investment policy, shall not be subject to either AEF or CAEF taxation.

Section 5. Use of Clinical Academic Enrichment Fund (CAEF). Monies in the CAEF must be used in ways consistent with the following:

(a) to finance new programs that are part of the clinical mission of the School of Medicine;

(b) these funds are not intended to replace or offset hospital support for clinical programs or faculty.;

(c) to strengthen and support existing and future clinical programs within the School of Medicine;

(d) to enhance clinical service, quality, access, and outcomes initiatives deemed to further the clinical mission;

(e) to invest in the new business opportunities, technology, and facilities that provide UPI and its departments diversified income streams;

(f) funds in the CAEF may not be used to support programs and activities associated with the academic and research missions of the School of Medicine which shall continue to receive their funding from the AEF;

(g) the UPI Board of Directors will establish or designate a UPI faculty advisory group to provide input into the CAEF allocation decisions;

(h) all expenditures from the CAEF must be consistent with UPI's charitable purpose and the University's clinical mission;

(i) the president will give the Board of Directors an annual report summarizing the expenditure of funds from the CAEF in the previous fiscal year.

[4] **Definition of Medical/Legal Revenue.** The term "Medical/Legal Revenue" shall mean all monies collected by or paid to UPI as compensation for a Member providing a professional opinion to or for the benefit of an attorney, a judge or an administrative agency, whether in a judicial or an administrative proceeding or in contemplation of one, including when the Member serves as an expert witness or as a consultant to or for the benefit of the individuals/entities listed above The term Consulting Revenue shall mean (as delineated in the Member Practice Agreement (MPA)) all monies, fees, retainers, or other compensation earned for performing administrative, consultative, teaching, lecturing, training or research services, or honoraria (excluding Exempt Honoraria as defined in the MPA).

Attachment A

2008 UPI Bylaws Committee

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