

The Regents of the University of California

COMMITTEE ON HEALTH SERVICES

June 14, 2016

The Committee on Health Services met on the above date by teleconference at the following locations: UCSF–Mission Bay Conference Center, 1675 Owens Street, San Francisco, and Covell Commons, Los Angeles campus.

Members present: Regents Lansing, Makarechian, Reiss, and Sherman; Ex officio member Napolitano; Executive Vice President Stobo, Chancellor Khosla; Advisory members Dimsdale, Hernandez, Lipstein, Ramsey, and Smith

In attendance: Secretary and Chief of Staff Shaw, General Counsel Robinson, and Recording Secretary Johns

The meeting convened at 12:35 p.m. with Committee Chair Lansing presiding.

1. READING OF NOTICE OF MEETING

For the record, it was confirmed that notice had been given in compliance with the Bylaws and Standing Orders for a special meeting of the Committee on Health Services to be held concurrently with the regularly scheduled meeting of the Committee for the purpose of considering the UC Health Medi-Cal strategy.

2. PUBLIC COMMENT

Committee Chair Lansing explained that the public comment period permitted members of the public an opportunity to address University-related matters. The following persons addressed the Committee concerning the items noted.

- A. Ms. Christina Hildebrand expressed concern about new immunization requirements for UC students, which she said went above and beyond California State law. Although medical exemptions are allowed under Centers for Disease Control and Prevention (CDC) contraindication guidelines, these guidelines are the strictest in the U.S. She cited the situation of families with children who have suffered harmful effects through vaccinations.
- B. Mr. Del Bigtree, a film and television producer, shared allegations that scientists at the CDC suppressed or destroyed data that showed a correlation between the measles, mumps, and rubella (MMR) vaccine and autism. He affirmed his belief that the MMR vaccine is dangerous to health and urged the University not to require this vaccination for its students. UC should allow exemptions to vaccination on religious grounds or based on family medical history.

- C. Ms. Janice Miller, a San Francisco resident, expressed concern about coercive vaccination policies. She asked how UC would inform its students about the risks of certain vaccines and decried the fact that students injured by a vaccination must prove their case in court. Pharmaceutical companies would not have liability.
- D. Ms. Angelita Garcia-Stonehocker described how one of her children had severe reactions to vaccinations received when he was an infant. Her children would not qualify for vaccine exemptions under the CDC guidelines. She asked the University to consider revising its guidelines on vaccination requirements for students. Some individuals have a genetic predisposition to adverse reactions to vaccination.
- E. Ms. Deborah Fairchild emphasized that UC and other colleges and universities must allow vaccination exemptions for students. Public health is important for all, but the rights of individuals to make decisions about their health should not be taken away.
- F. Ms. Marisa Davis Clark recounted her experience of the bad effects of vaccination received in college, arthritis in her hands which took two years to heal. She emphasized that vaccination injury can take various forms.
- G. Ms. Joy Dillow DuPuis voiced concerns about vaccine injury, noting that she and her daughter had the MTHFR gene variation, which might lead to adverse reactions to vaccinations. The University should allow vaccination exemptions based on religion.
- H. Ms. Beatriz Montalvo, a Ventura County resident, emphasized an individual's right of informed consent to a medical procedure. The appropriateness of the MMR vaccine might change over time for an individual.

3. **APPROVAL OF MINUTES OF PREVIOUS MEETING**

Upon motion duly made and seconded, the minutes of the meeting of April 18, 2016 were approved, Regents Lansing, Makarechian, Napolitano, Reiss, and Sherman voting "aye."¹

4. **UPDATE FROM THE EXECUTIVE VICE PRESIDENT – UC HEALTH**

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

Executive Vice President Stobo introduced Advisory member Lipstein, the President and Chief Executive Officer of BJC HealthCare in St. Louis, Missouri, which is associated with the Washington University School of Medicine. Mr. Lipstein was formerly Chair of the Board of Directors of the St. Louis Federal Reserve Bank.

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

Dr. Stobo remarked that a possible topic for discussion at an upcoming meeting would be the protection of the UC Health brand and the maintenance of its quality as UC develops clinically integrated networks and affiliations.

5. **UPDATE ON UC HEALTH MEDI-CAL STRATEGY**

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

Executive Vice President Stobo recalled that the explosive growth in Medi-Cal patient numbers had been discussed by the Committee at its February meeting. Since the implementation of the Patient Protection and Affordable Care Act in 2010 there had been an increase of over 20 percent in this population in California. Roughly 13 million patients, or one-third of the citizens of California, have Medi-Cal as their health insurance. The University is doing its fair share in providing services to this population.

The cost to UC Health the previous year due to the difference between Medi-Cal reimbursement and the cost of providing service, was about \$600 million to \$700 million. UC must find a more effective way to provide care. In terms of volume of Medi-Cal patients, UC hospitals rank number one or two in the state, depending on which affiliated hospitals are taken into consideration. If volume is divided by the number of hospitals or the number of patient beds, UC ranks in second place, while Sutter Health is in first place.

There is a perception in the State government that UC is not taking on its fair share of Medi-Cal patients. The Medi-Cal waiver is an allowance by the federal government to use Medi-Cal funds to provide services to patients who otherwise would not be included under Medi-Cal. This waiver is worth hundreds of millions of dollars annually to UC. As part of the waiver, some legislators wished to add an amendment under which every designated public hospital would be required to contract not only with the Medi-Cal plan in its immediate service area, but with every Medi-Cal plan contiguous with its service area. Under this scenario, some UC medical centers would have to have contracts with three Medi-Cal-managed care plans. The University was able to change the terms of the waiver. Each UC hospital would be required to have at least one Medi-Cal-managed care contract by January 2018. Dr. Stobo described this requirement as not unreasonable. The University still has much work to do in Sacramento to educate legislators about the University's contribution to Medi-Cal patient care. Dr. Stobo expressed the hope that UC Health would develop a coordinated systemwide Medi-Cal strategy.

6. **AMENDMENTS TO THE CLINICAL ENTERPRISE MANAGEMENT RECOGNITION PLAN**

The President of the University recommended that the Committee on Health Services recommend to the Regents that the Clinical Enterprise Management Recognition Plan be amended as shown in Attachment 1, subject to the Regents' approval of the related changes to Regents Policy 7712: Senior Management Group Incentive Awards.

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

Executive Vice President Stobo explained that the Clinical Enterprise Management Recognition Plan (CEMRP) is a performance-based plan that provides additional compensation to employees in the clinical enterprise. When Dr. Stobo began work at UC, changes were made to the plan, especially at the chief executive officer (CEO) level, by introducing systemwide goals for the CEOs. Systemwide goals must be accomplished as a system; if they are not achieved there is no individual payout. Currently, 50 percent of the performance-based compensation for CEOs is based on systemwide goals, while 50 percent is based on other specific goals. The amendments being proposed would add a long-term incentive component with multi-year goals, in recognition of the fact that it would take several years to achieve certain goals.

Executive Director Dennis Larsen underscored that CEMRP provides at-risk, variable incentive compensation opportunities for those employees responsible for achieving or exceeding key clinical, financial, and non-financial objectives such as quality of care, patient satisfaction, safety, or financial performance. The awards under CEMRP are funded exclusively from health services revenue; no State funds are used. Performance-based incentive plans are prevalent among higher education health institutions including teaching hospitals. CEMRP provides no payout if assigned objectives are not met. CEMRP was last revised by the Regents in July 2010, when a new governance structure, the Administrative Oversight Committee (AOC), was introduced. The CEMRP AOC is made up of the chancellors of campuses with medical centers, the Executive Vice President and Chief Operating Officer, the Vice President of Human Resources, and the Executive Director of Human Resources. The AOC has the authority to administer CEMRP, to implement non-substantive changes or technical corrections, and to approve participants' annual objectives and awards below the level of Executive Vice President – UC Health, as long as all actions are consistent with CEMRP as approved by the Regents.

The amendments being presented for the CEMRP were substantive and material changes that required Regents' approval. The changes proposed in the section of the plan titled "Plan Approval" were prompted by amendments to Regents Bylaw 12.7 on the authorities of the Committee on Health Services. Under the current CEMRP, the Committee on Compensation has authority to approve substantive changes to the plan. As a result of amendments to the Bylaw, the Chair of the Committee on Health Services would take on the role currently served by the Chair of the Committee on Compensation, approving substantive and material changes. The approval of the President would still be required.

The section of CEMRP on "Performance Objectives and Weightings" recognizes three categories of objectives for all participants: clinical enterprise systemwide objectives, institution-specific objectives, and individual objectives. The systemwide and institution-specific objectives emphasize teamwork and collaboration. Individual objectives are designed to maximize efforts by focusing on key initiatives under the control of that individual. Under the proposed changes, individual objectives would no longer be

assigned to the Executive Vice President – UC Health or the medical center CEOs. These employees would be assigned only systemwide and institution-specific objectives. Changes in the section on “Incentive Award Approval Process” would move authority from the Chair of the Committee on Compensation to the Chair of the Committee on Health Services.

The most important change to CEMRP being proposed was the establishment of a long-term incentive component for the Executive Vice President – UC Health and the medical center CEOs. This component would focus on long-term strategic objectives that often take many years to attain. One or more strategic objectives would be established by the President, who will consult with the Chair of the Committee on Health Services. These objectives would be established at the beginning of each fiscal year, with performance outcomes assessed at the conclusion of three years. Because participants would be required to be actively employed through the end of the three-year cycle to be eligible for a long-term incentive award, this component could have significant value as a retention tool. There would be no prorated award if participants leave prior to the conclusion of the three-year performance period. The proposed long-term incentive awards would have a threshold opportunity of five percent of base salary, target opportunity of ten percent, and a maximum opportunity of 15 percent. The awards would be paid only if the minimum threshold of performance is met or exceeded. If target performance is achieved, applying current salaries, the estimated annual cost for this component would be approximately \$488,000, funded by clinical revenues. No State funds would be used, and the cost would not be incurred until the conclusion of the initial three-year performance period in 2019, and only if the objectives are met.

Mr. Larsen concluded by noting that there were also proposed changes to CEMRP regarding separation from the University. Provisions for separation had been strengthened and clarified.

Regent Makarechian asked about the authority to approve CEMRP changes that are not substantive or material and requested a definition of materiality in this case. Mr. Larsen responded that most changes made to CEMRP since 2010 have only been changes to the effective date of the plan. CEMRP operates on an annual basis and has to be renewed every year. This change of date is a non-substantive, non-material change. Material changes, requiring Regents’ approval, would be changes that affect the payout, such as a change in the incentive targets. Terms and conditions that would change the ability of participants to receive a payout would also be material.

Regent Sherman asked if the three-year performance period would be a rolling three-year period. Mr. Larsen responded in the affirmative. The goals and objectives established in 2016 would be assessed in 2019. In 2017 a new set of goals and objectives would be established. If these are achieved, there would be a payout award in 2020, and so on.

Advisory member Dimsdale suggested that the CEMRP language explaining the purpose of the plan include language stating that UC Health sponsors innovation in addition to delivering care. He expressed his concern about faculty retention. The turnover rate for

physicians at UC medical centers is higher than for other campus faculty and staff. The percentage of UC medical faculty who remain after ten years is only 52 percent. Mr. Larsen responded that medical faculty issues are managed by a different group, Academic Personnel and Programs. CEMRP is a plan for administrators that focuses on the operational aspect of UC's health enterprise and does not apply to physicians. Dr. Dimsdale observed that UC medical center administration plays a role in physician morale and retention.

Advisory member Smith asked if the award percentages are based on annual salary or on salary over three years. Mr. Larsen responded that the percentages are based on annual salary.

Dr. Smith remarked that the University should consider the relative proportion of short-term versus long-term variable compensation for employees at this level of the institution. He stated his view that the award amounts were fairly small. Mr. Larsen responded that when the administration discussed available options, it was clear that UC Health was falling far behind the market, especially in CEO compensation. This market lag could be addressed by increases in base salary. UC tends to be conservative in its approach to compensation. While UC could increase the short-term, annual incentive component, discussions of this matter led to recognition of the need for UC Health to carry out long-term, strategic initiatives and the desirability of a long-term incentive component. A conservative approach was taken to the amount of the long-term incentive and the award percentage ranges, since this is a new concept for UC. Mr. Larsen noted that even with the ten percent target award, total direct cash compensation would still be at 86 percent of the market median. The long-term incentive component could be reviewed and adjusted in the future.

Regent Makarechian asked if the University had statistics on medical faculty retention and loss and information on the reasons why medical faculty leave the University. Mr. Larsen recalled that a total remuneration study for faculty had been carried out a few years earlier, including health sciences faculty. It was difficult to identify separately the various elements of compensation because each medical center reported and tracked compensation in a different way. There are generally three categories of compensation for the health sciences faculty under a different plan, the Health Sciences Compensation Plan (HSCP): base salary, a negotiated amount of compensation tied to productivity, and incentive compensation. These amounts are generally negotiated individually, usually by deans, and depend on a number of factors, such as practice area. Human Resources ultimately abandoned its effort to include health sciences faculty in the total remuneration study due to problems of comparison.

Regent Makarechian asked if the University conducts exit interviews of medical faculty who leave UC. Mr. Larsen responded that this was an academic personnel matter. Some information on this was being gathered and tracked, but he did not know how detailed it was.

Advisory member Hernandez referred to long-term incentives offered by competitor institutions and asked how the CEMRP long-term incentive component compared to the market. Mr. Larsen responded that the CEMRP long-term incentive component was at the low end of the market and represented a conservative approach. A survey of hundreds of academic and nonprofit medical institutions showed that 50 to 57 percent of these entities offer a long-term incentive component. This was becoming a prevalent practice, but Mr. Larsen judged that the practice was still in an early phase of its history. This was one reason for UC to take a conservative approach. Initially the University had considered targets of 15 to 20 percent, which would bring UC closer to the market median in its total direct compensation. But the general conclusion of the discussions was that this is a new approach and should be tested; it could be revised if needed.

UC San Diego Health CEO Patricia Maysent addressed the issue of faculty turnover. UC San Diego conducts exit interviews with departing faculty. There are four essential issues. The first is compensation. UCSD is in a very competitive market. Kaiser Permanente is opening a new facility in San Diego. The second issue is a question of lifestyle. Some younger faculty prefer the practice model at entities like Kaiser. The third issue is personalities in chair or division leadership, and fourth, there can be misalignment of the individual with division goals.

Advisory member Lipstein referred to Dr. Hernandez's earlier question. He explained that BJC HealthCare compensates its executives in three categories: a base salary, a variable component based on annual performance, and a variable component based on "high impact value creation," similar to the three-year long-term incentive being proposed for CEMRP. He recalled that BJC HealthCare had recruited an executive from UC San Diego at 60 percent of the market median. The annual variable component for this individual was 45 percent at target, and the high impact value creation target was 50 percent of base salary. Mr. Lipstein described a current trend among boards of private institutions to shift a greater portion of total compensation to variable components. These institutions evaluate their CEOs' annual performance against criteria such as quality, safety, satisfaction, financial performance, and how well they position the organization for long-term success.

UC Davis Vice Chancellor Julie Freischlag underscored that faculty attrition, at rates of 10 to 15 percent annually, is a common problem for academic medical centers. The workload for young medical faculty had become more burdensome over the past ten years in terms of work hours and numbers of patients. It requires a special kind of individual to be able to manage practice as a physician along with teaching and research. The University could do a better job of presenting the prospect of an academic medical career at UC in an attractive, positive light, especially for women physicians. It was important to retain young faculty through their first six to seven years by providing security, advancement, and the flexibility to raise a family.

UC San Diego Vice Chancellor David Brenner reported that the annual attrition rate was eight percent for clinical faculty at his institution. Roughly one-third of these faculty retire, one-third leave for other academic medical centers, and one-third go into private

practice. Those going into private practice are predominantly primary care physicians, while those leaving for other academic institutions tend to be subspecialists.

Upon motion duly made and seconded, the Committee approved the President's recommendation and voted to present it to the Board, Regents Lansing, Makarechian, Napolitano, Reiss, and Sherman voting "aye."

7. **FINANCIAL UPDATE FOR UCSF HEALTH, SAN FRANCISCO CAMPUS**

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

UCSF Health Chief Executive Officer Mark Laret recalled that in January 2013 the Regents approved a formal affiliation between UCSF and Children's Hospital and Research Center Oakland (CHRCO). Upon closing of that transaction one year later, in January 2014, the Regents became the sole member of the Children's Hospital Corporation. But the University continues to operate this facility as a private, non-for-profit hospital. Following a gift from Marc and Lynne Benioff in 2014, CHRCO was renamed UCSF Benioff Children's Hospital Oakland (BCHO). The members of the BCHO board of directors are appointed by the Chancellor of UCSF. UCSF wished to achieve efficiencies by linking BCHO and the Benioff Children's Hospital in San Francisco and to expand its presence in the East Bay for competitive reasons. BCHO's strong balance sheet is a positive addition to UCSF Health. Currently, two-and-a-half years after the closing of the transaction, most of UCSF's goals had been met to varying degrees. The integration of UCSF faculty and private medical staff in Oakland was still a challenge, as was managing a high proportion of Medi-Cal patients. Seventy percent of the Oakland patients are Medi-Cal patients. This needed to be considered in connection with the chronic underfunding of the Medi-Cal program in California and the competitive children's healthcare market in Northern California.

In order to meet State seismic requirements and to modernize facilities at BCHO, UCSF was currently engaged in constructing a 90,000-square-foot, \$180 million ambulatory care facility on the hospital's campus. The Regents had approved a refinancing of CHRCO debt in March 2014. At that time, UCSF indicated that it planned to request an additional \$50 million in external financing for CHRCO capital improvements, and this request would be brought to the Board at the upcoming July meeting. The Regents would borrow on behalf of UCSF Health; UCSF Health in turn would lend to BCHO, which would repay the debt. One strong reason for the project was that it would free up space for inpatients. The project's total cost was \$180 million. Ninety million dollars would be funded by philanthropy, and UCSF had raised about \$87 million of this amount. The remaining \$90 million would be funded by hospital equity and debt, the debt that would be requested in July. Mr. Laret affirmed that BCHO had sufficient reserves to cover equity and any shortfalls in philanthropy.

UCSF Health Chief Financial Officer Barrie Strickland explained that UCSF Health was currently a \$3.5 billion enterprise in fiscal year 2016, growing to almost \$4 billion in

fiscal year 2017. The UCSF Health organization includes several components. The “West Bay” operations are the UCSF Medical Center, the UCSF faculty practice, and the Langley Porter Psychiatric Hospital and Clinics. Included in the UCSF Medical Center is the Benioff Children’s Hospital of San Francisco. The West Bay accounts for 86 percent of UCSF Health revenue. BCHO is a \$500 million enterprise, or 14 percent of UCSF Health.

Ms. Strickland reviewed the financial status of the UCSF West Bay operations for the first ten months of fiscal year 2016, through April. This had been the first full year of operations for the \$1.5 billion Mission Bay Hospital. UCSF was proud of the fact that this project had been delivered on time and under budget. As expected and planned, UCSF has had to absorb well over \$150 million in depreciation, interest, and increased operating expenses since the opening of the Mission Bay Hospital. She presented a chart showing that hospital discharges in fiscal year 2016 had grown by 12 percent over the prior year. UCSF West Bay operations had generated strong earnings before interest, depreciation, and amortization (EBIDA) of 20 percent over budget. There had been an \$18 million loss in net income, but this was \$27 million better than the \$45 million loss budgeted at the beginning of the year. The number of days’ cash on hand, 41 days, was 13 days better than projected at the beginning of the year. UCSF would like the cash balances for its West Bay operations to exceed 60 days.

The implementation of the Patient Protection and Affordable Care Act had intensified competition with Stanford Health Care, Sutter Health, and Kaiser Permanente to a level not experienced before. In order to compete as it must, UCSF was investing in new partnerships with John Muir Health, Dignity Health, Washington Hospital, and Marin General Hospital, and developing its own new Accountable Care Organization. These partnerships help build UCSF’s capacity to meet growing demand for its services. UCSF was balancing the competing interests of building up its cash balances versus deploying cash to secure its future in this market. Overall, the West Bay operations were performing better than expected.

Ms. Strickland then discussed the financial status of BCHO for the same period. BCHO revenue was \$405 million, and it had 167 days’ cash on hand. Cash reserves including fundraising were strong; however, net income was a negative \$68 million. She presented a chart listing the four major variables that accounted for the difference between the budgeted income for fiscal year 2016, \$8 million, and the ten-month performance, a loss of \$68 million. The first variable was actual hospital performance. BCHO’s census was lower than budgeted this year by 11 percent, and UCSF had invested more heavily than planned in building a physician practice network. This variable accounted for \$7.3 million of the difference between the budgeted gain and actual loss. The second variable was new pension assumptions, which accounted for \$6.9 million of the difference. The third variable, nearly \$27 million, was the difference between the budgeted investment income, \$7 million, and actual investment performance, an unrealized \$20 million loss. The UC medical centers’ cash balances are invested mostly in the Short Term Investment Pool (STIP), and some in the Total Return Investment Pool (TRIP), where returns are relatively predictable, even in an unfavorable market. BCHO

invests its cash, including philanthropic funds, through the UCSF Foundation and has greater exposure to market fluctuations. UCSF was seeing improvements and hoped for a small investment income gain in fiscal year 2017. The fourth variable was provider fee monies. Like many safety net hospitals in California, BCHO relies on supplemental Medi-Cal funds, like the hospital provider fee program. UCSF fully expected to receive an additional \$35 million for this year, but until the State and federal governments fully signed off on this year's payment, UCSF would not accrue this amount. UCSF had been assured by the State that this money would be forthcoming this summer. Sixty-two million dollars of the difference between budgeted income and actual loss could be attributed to unrealized investment variation and the delay in receiving provider fee payments from the Medi-Cal program. While this still left a \$14 million budget variance, UCSF understood the cause for this remaining gap and was budgeting appropriately in fiscal year 2017. Ms. Strickland then briefly summarized the financial status for the entire UCSF Health entity for fiscal year 2016. The overall net income loss was greater than originally budgeted due to the issues at BCHO just mentioned. EBIDA remained strong, better than budgeted, and combined days' cash on hand was 61 days, six days better than budgeted.

The UCSF Health financial plan reflects strong historical performance, a decline in fiscal years 2015 and 2016 due to depreciation, interest, and operating costs of the Mission Bay Hospital, and a forecast for five years into the future with stronger performance, including stronger net income performance. The EBIDA trends are similar to those for income. A forecasted stronger EBIDA would occur through strategic growth and continuing actions to lower costs. UCSF's cost improvements included leveraging scale for value, productivity and asset use improvements, and shared service initiatives. UCSF's number of days' cash on hand was budgeted to decrease in fiscal year 2017. To secure its future in a competitive market, UCSF plans to deploy cash carefully and to continue to invest in its facilities, partnerships, and its academic mission. Ms. Strickland anticipated that with improved earnings, UCSF's number of days' cash on hand would rise to over 60 days by fiscal year 2019. UCSF was optimistic about its future and its ability to service the proposed incremental \$50 million of debt to be presented at the July meeting.

Committee Chair Lansing asked if there were any lessons to be learned from this situation. Mr. Laret responded that there are always increases in depreciation and interest expenses when new hospitals begin operation, such as the hospital at Mission Bay. While some peripheral matters might have been managed more efficiently, the increase in Medi-Cal patients was a significant issue. UCSF estimated a loss of \$260 million for the past year due to Medi-Cal. He stressed UCSF's commitment to its public mission but identified the growth in Medi-Cal and the associated unsatisfactory reimbursement as the one major factor not anticipated by UCSF. The Medi-Cal situation was particularly challenging for UCSF and UCLA. The University would pursue solutions with vigor, even marginal ones.

Committee Chair Lansing stated that even marginal solutions can make a tremendous difference. Executive Vice President Stobo responded that UC would seek improvements in care management, coordination, and maximizing reimbursement.

Advisory member Lipstein observed that there was a general lesson to be learned beyond the specific situation of UCSF. American hospitals have an appetite for state-of-the-art facilities, equipment, and instrumentation, but technology upgrades are rarely accompanied by incremental revenue. The dilemma was one of trying to keep pace with the rate of change without increasing costs.

Advisory member Hernandez suggested that UC should study how Sutter Health has gone about the management of its Medi-Cal patient population, including creative partnerships and collaborations. She asked about the reasons for the decline in patient volumes at BCHO. Mr. Laret responded first about the Medi-Cal issue. One of UCSF's tasks is to determine what its role in the Medi-Cal program should be. UCSF tends to receive referrals for tertiary and quaternary specialty care from outside the region, where Medi-Cal-managed care plans wish to pay the same rate as they pay to hospitals providing routine care. In response to the question regarding decline in patient volumes at BCHO, he stressed that this hospital finds itself in a competitive marketplace. Some BCHO physicians had left, choosing to join the Stanford physician network. Stanford has established an outpatient center in Emeryville and a partnership with John Muir Health in Walnut Creek. There may also have been some movement of patients from the East Bay to the Mission Bay Hospital. BCHO is a community children's hospital, and its financial performance can be affected by what are in fact desirable circumstances in the community, like a decrease in the number of trauma cases. UCSF is examining patient outreach efforts in the Central Valley, South Bay, and North Bay.

In response to questions by Regent Sherman, Ms. Strickland responded that the BCHO EBIDA for the current year, without the unrealized investment loss, was projected to be an \$11 million shortfall. UCSF has budgeted a \$9 million favorable EBIDA for fiscal year 2017, based on strategic growth initiatives, improving access to specialists, and reducing costs. The investment income budgeted in fiscal year 2017 would be \$8 million, not included in the EBIDA number. Of the \$237 million BCHO cash reserves, approximately \$200 million was in UCSF Foundation funds. A small portion of that money was restricted, about \$35 million, but the remainder was available for capital and other programs. Mr. Laret added that a common model in children's hospitals is to raise money for current operating needs.

Regent Sherman asked if the \$40 million in equity required for the project would come from those cash reserves. Mr. Laret responded in the affirmative.

Regent Makarechian asked why the \$35 million expected from the State had not been accrued, suggesting that it could be applied to the \$50 million in debt for the project. Ms. Strickland responded that the \$35 million had been budgeted for the month of June. For accounting purposes, UCSF must wait for formal approval by the State and federal governments, which have assured UCSF that they would approve the provider fee

program for the managed Medi-Cal patient population. This \$35 million is part of UCSF's annual earnings. The \$50 million in debt is additional borrowing that UCSF had already included in its financial plan to pay the \$180 million total project cost.

Advisory member Smith observed that the profile of the Medi-Cal population since the advent of the Patient Protection and Affordable Care Act would likely be different from past perceptions of this population and would include more men, adults, and working people. He asked about Ms. Strickland's earlier remarks about BCHO's investments through the UCSF Foundation and expressed concern about the exposure to market risk. Ms. Strickland acknowledged that BCHO's cash investments are exposed to a greater degree of risk than those of the medical centers because they are managed through the UCSF Foundation, while the UC medical centers' investments are consolidated with the overall investments at the Office of the President. Mr. Laret added that much of the \$237 million in BCHO cash reserves was derived from philanthropy. The investment of these philanthropic funds is the same as that for other such funds in the UCSF Foundation. The board of the Oakland Children's Hospital had historically been investing in this manner, through an outside manager. This approach was continuing, but through the UCSF Foundation. He emphasized that UCSF was aware of and wished to avoid vulnerability to the market.

Regent Sherman suggested that it might make sense for the UCSF Foundation to invest through the Office of the President, noting that on average, campus foundation investments do not perform as well as the Office of the President's investments. Committee Chair Lansing observed that the campus foundations, often made up of philanthropists themselves, may view the Office of the President's investment strategies as rather conservative and risk-averse, but that the University should consider this possibility. Regent Makarechian remarked that a change of this kind would be enormous and might be difficult from a legal standpoint. President Napolitano recalled that significant changes were made at the Office of the Chief Investment Officer about two-and-a-half years prior, with a noticeable increase in returns. Because investment performance had not been as good in the past, there was no incentive for the campus foundations to have their investments managed by the Office of the President. The Chief Investment Officer has discussed this matter with the campuses, and several foundations have agreed to this. The University was reducing the number of outside fund managers. The Office of the President would continue to work with individual campus foundations, and a systemwide approach made sense.

Advisory member Ramsey commented on the budget risk related to new personnel when a facility is opened. He asked about UCSF's projection of workforce expenses and its ability to hire necessary nursing staff. Ms. Strickland responded that UCSF had planned carefully for the opening of the Mission Bay Hospital, fine-tuning its preliminary projections for incremental staff, and had been able to hire staff as planned, some temporary contract labor workforce and some overtime. Over the past year UCSF had been working to balance this out with hiring of permanent employees.

Regent Sherman asked about the types of cash outflow at UCSF other than for specific new projects, such as costs for ongoing capital improvements. Ms. Strickland responded that UCSF's capital expenditures were approximately equal to UCSF's depreciation expenses. There are interest expenses on borrowings, and cash disbursements after EBIDA represent funding for research.

Dr. Hernandez noted that once charitable gifts are made, the purpose for which those assets are used can be restricted, but donors cannot determine how the gifts should be invested. The University should study the asset management strategies of the Office of the President and the foundations, especially regarding volatility, to determine if leverage in either direction is possible.

Regent Makarechian asked if the EBIDA projections included the \$50 million in debt for the project. Ms. Strickland responded in the affirmative. The financial projections for income, cash and EBIDA, included the \$50 million borrowing. This represented about \$1 million annually in additional interest expense less interest income, with an approximately 0.3-day impact on the debt service coverage ratio.

Executive Vice President Stobo added that the dashboard information system being developed by UC Health would allow UC to examine the financial status of each of its five medical centers.

Mr. Lipstein suggested that using a common set of investment managers UC-wide would provide economies of scale, and that one could still allow foundations the flexibility to choose their asset allocation among those fund managers. He then drew attention to an important upcoming development in federal funding. The Patient Protection and Affordable Care Act presumed that every state would expand its Medicaid program and reduce the number of uninsured proportionally across the U.S. The federal government allocates "disproportionate share hospital funding" to the states based on each state's percentage of Medicaid days and Social Security income patients. California, a state that has greatly expanded Medicaid, has many Medicaid days. The federal government was planning to move from an allocation based on Medicaid days to an allocation based on uncompensated care. When this transition occurs, California would move from receiving \$1,254,000,000 annually to receiving \$900 million, a net reduction of \$350 million. Hospitals would not be allowed to count their Medicaid shortfall as part of uncompensated care. Consideration of the disproportionate share hospital allocation would be very important in the University's Medi-Cal strategy. Dr. Stobo asserted that UC would be mindful of these developments. UC Health is attentive to the financial status of each medical center. When UC Health borrows money on the debt market, rating agencies regard UC Health as an obligate group.

8. **STRATEGIC PLAN FOR UC HEALTH'S CLINICAL ENTERPRISE**

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

Executive Vice President Stobo recalled that the restructured Committee on Health Services now had authority for a number of different kinds of transactions as well as certain responsibilities. One responsibility is to oversee the development of a strategic plan for the clinical enterprise; another is to develop a dashboard information system that provides indicators of quality, safety, outcomes, and the value added by services the clinical enterprise provides.

Dr. Stobo emphasized that the strategic plan is a living document and asked the Committee to consider whether the strategic plan was on the right track and whether a report on the strategic plan to the full Board of Regents should be presented in July or at a later meeting. Committee Chair Lansing suggested that this report be rescheduled from the July to the September meeting.

Dr. Stobo briefly presented UC Health's statements of its mission and vision. By fiscal year 2020, UC Health would look markedly different than it did at present in areas such as patient-centeredness and service to patients from all walks of life. The clinical enterprise must be able to demonstrate value through cost, quality, and data to advance care. There would be strategic and operational alignment across the medical centers and deliberate growth across California and the Western states. Financial viability was essential to sustain the clinical enterprise, including its support for the academic mission. UC Health needs to have strong and engaged governance body.

UC Health aims to achieve synergies and has six important strategic goals. Dr. Stobo underscored one of these goals, innovation, to amplify UC Health's research impact, and to use the research mission to drive clinical strategy, particularly concerning patient data. UC Health's tactics follow its strategy. UC Health planned to grow region by region with affiliations and investment, to expand its tele-health platform, to launch a focused, systemwide Medi-Cal effort, and to augment its quality, cost, and access reporting capability. UC Health would scale its Big Data initiative from pilot to systemwide implementation. This initiative involves access to 15 million unique patient records and over 100 phenotypic characteristics. These data could be better used than they were at present for important clinical decisions. Dr. Stobo concluded that UC Health's strategic plan was not meant to displace local strategic plans, but to enhance and support them.

Committee Chair Lansing in particular praised aspects of the plan concerning UC's ability to apply data from research to patient care, and to secure more participants for clinical trials.

UCSF Health Chief Executive Officer Mark Laret quoted a statement about the mission of academic medical centers by three health professionals associated or formerly associated with UCSF, published in the *Journal of the American Medical Association*, according to which this mission is the improvement of health and health care through advancement, application, and dissemination of knowledge.

President Napolitano recalled that the current year State budget included \$22 million for innovation efforts at UC, over and above increases to the core operating budget. The UC

medical centers and the UC-affiliated National Laboratories would be involved in research as part of the national Cancer Moonshot initiative. The National Laboratories and the campuses were also collaborating on the development of computational modeling and the possibility of virtual clinical trials.

Advisory member Lipstein identified the topics just mentioned by Committee Chair Lansing, Mr. Laret, and President Napolitano as sustainable advantages of the University of California. A sustainable advantage is one that other entities cannot easily replicate. Recognition of these sustainable advantages should be part of the foundation of UC Health's strategic plan. Dr. Stobo concurred, stating that UC was striving to identify what it does differently than all its competitors. UC may not always be able to compete in the area of cost.

Mr. Lipstein observed that concerns might arise about dilution of the UC brand as UC Health develops its clinical network. One challenge for UC is incorporating its sustainable advantages and its approach to clinical integration into the strategic plan.

Advisory member Ramsey noted that the phrase "care transformation" is often used in clinical strategic planning. Research was now moving faster than ever before and changing the knowledge base. Healthcare services research was demonstrating new ways to practice medicine. One advantage of UC is its status as a strong educational institution, and this education should include the continuing education of practitioners.

Committee Chair Lansing emphasized that the strategic plan is a living, breathing document which would change and respond to changes in the world of health care. Dr. Stobo responded that certain aspects of the plan, the strategy, would be immutable, while tactics might change.

Dr. Hernandez indicated that she had served as an outside advisor to UC efforts in the areas of criminal justice and health. These efforts had been effective in leveraging collaboration among all the campuses and they were a good example of the systemwide culture that UC Health was seeking to build. Another important element of the strategic plan should be workforce concerns. California does not have a statewide plan for its future healthcare workforce needs, although there are ongoing discussions of needs and gaps. UC Health has a significant role to play in leading the discussion of this matter.

Regent Reiss referred to the goal of financial viability, articulated in UC Health's vision statement, and to grave financial projections presented at earlier meetings. She asked if the detailed strategic plan to be presented would show a path to changing this trajectory, or if this work was still in progress. Dr. Stobo responded that the strategic plan would provide a blueprint for UC Health to remain financially vigorous.

9. **CLINICAL QUALITY DASHBOARD FOR UNIVERSITY OF CALIFORNIA MEDICAL CENTERS**

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

Executive Vice President Stobo recalled that the Committee on Health Services is responsible for overseeing the development of a quality dashboard information system and to hold UC Health accountable to that dashboard on a regular basis.

UCSF Chief Medical Officer and Executive Vice President – Physician Services Joshua Adler explained that performance measurement in health care is a field still in development. In its own performance measurements, UCSF has more than 700 individual quality and safety criteria. Some of these criteria are required by external entities, while others are not. This situation is typical for UC Health and for all major health systems across the country.

There are many aggregators of healthcare performance measurement in the U.S., such as *U.S. News and World Report*, the Leapfrog Group, and *Consumer Reports*. They try to provide a score or assessment of the performance of hospitals and health systems, but choose different criteria and priorities, and inevitably produce very different rating or scoring systems. While this indicates that healthcare performance measurement is a new field, Dr. Adler emphasized the importance of performance measurement for improving performance.

The goal of the UC Health quality dashboard is to develop a reliable picture of quality and safety in the UC Health system and to help to provide a guide for improvement. Dashboard criteria should be meaningful for UC, its patients, and external entities. They should be actionable and provide reliable measures. Dr. Adler outlined the planned phases of development for the dashboard, beginning with inpatient data, then proceeding with data for ambulatory care, value and cost, and big data and high-level analytics.

Dr. Adler then discussed a first subset of inpatient quality criteria. The first criterion was inpatient mortality, the rate at which patients die in UC hospitals, a risk-adjusted measure. UC uses the risk adjustment provided by the University Health System Consortium (UHC), also known as Vizient. All major academic medical centers participate in this entity. He showed a chart showing UC inpatient mortality rates compared to UHC averages.

Committee Chair Lansing asked which factors were included in the risk adjustment and requested clarification of the chart. Dr. Adler responded that the risk adjustment generally includes age, gender, and some information about the patient: the reason for hospitalization as well as other chronic conditions. The chart displayed the ratio of whether a patient, based on age and condition, is expected to die during the hospital stay or not.

In response to another question by Committee Chair Lansing, Dr. Adler confirmed that this chart would help determine preventable mortality rates, but noted that the science of performance measurement had not yet reached a level where it could indicate which cases of mortality could have been prevented.

Regent Sherman observed that the dashboard criteria and definitions would be of value only if they are consistent across the medical centers and over time. UC Health must be able to respond quickly to dashboard indicators such as mortality. Dr. Adler responded that the five UC medical centers are using the same criteria, definitions, and system of measurement, but that other health systems in the U.S. are most likely using other standards.

Advisory member Lipstein remarked that the academic medical centers surveyed for these data were not the same in terms of the populations they serve. The data were not risk-adjusted for socioeconomic status. Expected mortality ratios might be very different for wealthy versus poor patients, independent of the quality of care provided by a hospital. The question of whether one should include socioeconomic status in risk adjustment, as part of evaluating clinical performance, was being discussed nationwide.

Regent Sherman stressed his view that the presence or absence of this criterion was less important than applying criteria consistently over time in order to be able to identify trends. Dr. Adler responded that timeliness is a challenging issue for UC in making use of performance measure data. In order to secure uniform risk adjustment methodology, UC currently submits data to an aggregator for analysis, such as UHC in this case. The most recent risk-adjusted data currently available were those for the fourth quarter of 2015. Certain data or measures can be tracked closer to real time.

Regent Sherman asked why the University relies on an outside provider for this service. Dr. Adler responded that UC benefits from the fact that the outside provider has developed a nationally recognized risk adjustment methodology and benchmarks.

Dr. Adler then discussed another criterion, the 30-day all cause patient readmission rate. This measure is not risk-adjusted and therefore controversial. Nevertheless, it is tracked by UC Health. While UC inpatient mortality rates were lower than the national average at all UC medical centers, this was not the case for readmission rates.

Committee Chair Lansing criticized this criterion as unfair. In cases of severe disease or populations who have not received much medical attention in the past, it may not be the fault of the hospital that some patients are readmitted. She asked how the University might explain this criterion.

Advisory member Smith noted that there had been a significant reduction in readmission rates in many hospitals over the past three years. Since receiving a financial signal from the Patient Protection and Affordable Care Act that they would not receive reimbursement for unexpected readmissions, hospitals have found ways to perform better. Mr. Lipstein expressed disagreement with this view. Committee Chair Lansing

suggested that this matter be discussed further and requested more information. She acknowledged that hospitals make errors that lead to readmission, but some readmissions are due to the nature of certain diseases. UCSF Health Chief Executive Officer Mark Laret stressed that the reason the patient readmission rate was included as a criterion was because of its financial implications. UCLA Vice Chancellor John Mazziotta observed that readmission rates could be affected in certain ways that would not have an impact on patients. At the UCLA Santa Monica Hospital, an extensive effort has been made to obtain and code all information about a patient's condition and illnesses, which has changed the ratio for expected mortality. All hospitals are pursuing this approach in order to better understand their patient populations. He noted that outpatients who receive acute care for a period of less than 24 hours would not count toward the number of readmissions.

Dr. Adler continued and presented another criterion, patient satisfaction, and a chart based on surveys of patients discharged from U.S. hospitals. These surveys are conducted by the Hospital Consumer Assessment of Healthcare Providers and Systems and mandated by the Centers for Medicare and Medicaid Services. The information in this chart reported patients' likelihood to recommend a UC hospital. He pointed out that performance measure data allow UC to understand differences among the medical centers and to facilitate better performance.

Regent Makarechian referred to information in the last three charts presented, which showed increases in inpatient mortality and readmission rates, and a decrease in patient satisfaction at the UC Irvine Medical Center between the third and fourth quarters of 2015. He asked what conclusions one might draw from these data. Dr. Adler cautioned against drawing an overarching conclusion based on data from only one quarter to the next, because there may be unpredictable events and changes in patient demographics. He emphasized that UC tries to identify trends. If one observed increases in multiple types of infections and increasing mortality, or increasing sepsis rates and mortality over more than one measurement period, that would certainly be understood as a signal. There is enough variation between quarters in general so that changes like those referred to by Regent Makarechian cannot be identified as an early signal.

Regent Makarechian asked about the usefulness of examining these criteria together. Dr. Adler responded that this approach allows UC to determine average performance. As an example, the UCLA Santa Monica Hospital might consistently perform better than other UC hospitals on various criteria, and the other hospitals can learn from UCLA Santa Monica. He observed that individual changes over time in short periods are of lesser concern; UC Health is more concerned about overall trends among its hospitals, benchmarks moving in a negative direction over multiple periods, and the ability to pinpoint problems at specific locations. The dashboard should be able to describe, on balance, the quality of UC Health.

Regent Makarechian asked if any of these criteria would be included in determining incentive compensation for clinical enterprise managers. Dr. Stobo responded in the

affirmative. Patient readmission rates are included in the criteria for the Clinical Enterprise Management Recognition Plan.

Regent Reiss referred to data in the charts provided that showed that the UCLA Medical Center had the highest or high rates among the UC medical centers for inpatient mortality, readmission, hospital-acquired pressure ulcers, and catheter-acquired urinary tract infections, yet the UCLA Medical Center also had a high rate for patient satisfaction. She asked how these dashboard data should be interpreted. Dr. Mazziotta responded that these data involved different variables that could not be reconciled.

Regent Sherman asked if the outside provider conducts studies on the interrelationship of the various criteria and could provide alerts. Dr. Adler responded that UHC, one of the data aggregators, uses its own methods to determine which criteria are the most significant indicators of overall quality or performance. UHC's methods are different from those of other data aggregators, and the ratings for a hospital by different data aggregators are virtually never the same, although presumably based on the same data. He stressed that most criteria concern undesirable outcomes for patients and the data are important for achieving improvements at UC Health. While UC Health might not be able to reduce readmission rates to zero, it most likely could reduce them to below 12 or 13 percent.

Mr. Lipstein observed that hospitals, as well as the federal and State governments, declare the absence of readmission to be a good outcome, while not having data on what has happened to the patient.

Dr. Adler then briefly presented another criterion and chart, the percentage of patients with hospital-acquired pressure ulcers, commonly referred to as bed sores. He noted that until about seven years earlier, bed sores were considered a routine occurrence in hospitals, and there was no notion that they might be preventable. In the past, five to six percent of UC patients had bed sores. Over several years, UC hospitals have been successful in reducing the incidence of bed sores.

In response to a question by President Napolitano, Dr. Adler acknowledged that the UCLA and Irvine hospitals showed an increase in the percentage of patients with pressure ulcers for the third quarter of 2015. As a measure of performance, hospital-acquired pressure ulcers are not risk-adjusted. Patients with certain kinds of illnesses are at greater risk, such as cancer patients, patients receiving orthopedic surgery, or patients with severe immune system dysfunction. The number of such patients might account for this increase, or it may have been that improvement efforts were not adhered to. In conclusion, Dr. Adler briefly mentioned a final criterion, urinary tract infections associated with a catheter. For this risk-adjusted measure, UC Health performs better than predicted, but there was room for improvement in reducing the number of these infections.

Dr. Stobo observed that UC Health would be able to make very effective use of its 15 million patient records, but it was not yet mining these data or using them

appropriately. UC Health is being held accountable by external agencies for the performance measures just discussed, and there would be further presentations about these benchmarks at future meetings.

Regent Makarechian asked whether UC Health has access to information about a patient's income level, ethnicity, and other characteristics. Dr. Adler responded that UC Health has access to data on age and gender, to some extent on race, and on associated clinical conditions for patients with undesired outcomes. UC Health does not have data on income level, but might estimate this based on a patient's zip code.

Regent Makarechian stated that zip codes are not a reliable indicator of income level. He asked if Medi-Cal or Medicare might provide any indications of patient income level. Dr. Adler responded that UC Health can consider patients by payer class, but noted that a survey at UCSF showed that the factor of payer class itself, Medi-Cal versus other forms of insurance, did not indicate a higher rate of readmission.

Dr. Stobo opined that 30 days might be too long a period to use as a relevant benchmark for patient readmission, while a period of seven days would be more indicative. If a patient is readmitted within seven days, there has likely been a problem with the hospital discharge process. Dr. Adler responded that most UC Health sites were examining patient readmission at the seven-, 14-, and 30-day mark, and these different periods display different patterns. Early readmissions, within seven days, are more likely to be preventable. Readmissions that occur later may also be preventable, but preventable by other parts of the health system, such as ambulatory care or primary care. UC Health would examine early and late readmissions.

Dr. Smith observed that even in the best of situations, the financial position of certain stand-alone hospitals would deteriorate if they are not connected to a broader network. He proposed another performance measure, of ambulatory care-sensitive conditions, in order to determine how many patients might not belong in a hospital and how much UC should be investing in outpatient care. Mr. Laret suggested that at the next discussion of this topic, UC Health could present a list of all the performance benchmarks or criteria it uses.

The meeting adjourned at 3:30 p.m.

Attest:

Secretary and Chief of Staff

Additions shown by underscoring; deletions shown by strikethrough

**The University of California
Clinical Enterprise Management Recognition Plan (CEMRP)
For Plan Year July 1, ~~2015~~2016 through June 30, ~~2016~~2017**

1. PLAN PURPOSE

The purpose of the University of California Clinical Enterprise Management Recognition Plan (CEMRP or “Plan”) is to provide ~~performance-based~~ at-risk, variable incentive compensation opportunity to those employees responsible for achieving or exceeding key Clinical Enterprise objectives. Consistent with healthcare industry practices, UC ~~medical centers~~Health Systems use performance-based (incentive) compensation programs to encourage and reward ~~quality patient care and operational efficiency among employees at every level.~~ Achievement is measured based on achievement of specific financial and/or non-financial objectives, (e.g., quality of care or patient satisfaction and safety, budget performance) and strategic objectives which relate to the Clinical Enterprise’s mission.

The annual Short Term Incentive (STI) component of the Plan provides participants with an opportunity to receive a non-base building cash incentive based on the achievement of specific annual financial, non-financial, and strategic objectives relative to the mission and goals of the UC Health enterprise.

The Long Term Incentive (LTI) component is a non-base building incentive that is intended to encourage and reward top executives of the UC Health enterprise for the achievement of multi-year strategic initiatives, to support and reinforce those results that will promote UC Health and its long-term success, and emphasize the importance of the long-term strategic plan. In addition, the LTI assists in retaining the executive talent needed to achieve multi-year organizational objectives by complementing (but not duplicating) the focus of the rest of the Clinical Enterprise Management Recognition Plan. The Executive Vice President (EVP) – UC Health and the Chief Executive Officers (CEOs) of each of the Health Systems will participate in the LTI.

The overall Plan encourages the teamwork required to meet challenging organizational goals. The Plan also uses individual and/or departmental performance objectives to encourage participants to maximize their personal effort and to demonstrate individual excellence.

2. PLAN OVERSIGHT

Development, governance and interpretation of the Plan will be overseen by an independent Administrative Oversight Committee (AOC) comprised as follows:

- Executive Vice President – ~~Business Operations~~Chief Operating Officer
- The Chancellor of every campus with a ~~medical center~~Health System
- The Vice President – Human Resources
- The Executive Director – Compensation Programs and Strategy

The AOC, in its deliberations pertaining to the development or revision of the Plan, ~~will~~may consult with the ~~Senior Vice President—EVP – UC Health Sciences and Services,~~ and representatives from the ~~medical centers comprised of a Chief Medical Officer, a Chief Nursing Officer, and a Chief Human Resources Officer, each selected from a UC medical center.~~Health Systems. The AOC will abide by the Political Reform Act, which would prohibit Plan participants, ~~such as the Senior Vice President—Health Sciences and Services, Chief Medical Officers, Chief Nursing Officers, and Chief Human Resources Officers,~~ from making, participating in making, or influencing decisions that would affect whether they participate in the Plan, the objectives that will govern whether they earn awards under the Plan, and the amount of awards paid to them under the Plan. The Office of General Counsel will be consulted if there are any questions about the application of the Political Reform Act in this context. The Senior Vice President – ~~Chief Audit and Compliance~~ and Audit Officer will assure that periodic auditing and monitoring will occur, as appropriate.

3. PLAN APPROVAL

The Plan will be subject to an annual review conducted by the AOC to address design issues and market alignment. The Plan will be implemented each year upon the approval of the AOC if no changes to the Plan are being recommended.

If the AOC recommends any substantive or material changes to the Plan, including, but not limited to, changes in the award opportunity levels, the AOC will obtain the approval of the President and the Regents' ~~Committees on Compensation and~~Committee on Health Services before implementing such changes. Reasonable efforts, given all circumstances, will be made to delay implementing substantive or material Plan changes until after the end of the current Plan year. However, if changes are implemented during the Plan year that would affect the award calculations, changes will only be applied prospectively to the remaining portion of the Plan year. Plan changes recommended by the AOC that are not material or substantive, or are deemed to be technical corrections, may be approved by the AOC after consultation with the President and ~~the Chairs of the Regents' Committees on Compensation and Health Services and~~ will then be implemented by the AOC at an appropriate time. The Regents will receive reports of all changes to the Plan.

4. PLAN YEAR

The ~~CEMRP Plan~~ year will correspond to the University's fiscal year, beginning July 1 and ending the following June 30.

The applicable performance period for CEMRP's LTI component will begin July 1 of the Plan year and end three years later on June 30th.

5. PLAN ADMINISTRATION

The Plan will be administered under the purview of the Executive Director – Compensation Programs and Strategy, at the Office of the President, consistent with the Plan features outlined in this document, and as approved by the President and the Regents' Committee on Health

Services. The Plan features and provisions outlined in this document will supersede any other Plan summary.

6. ELIGIBILITY TO PARTICIPATE

~~Eligible participants in CEMRP are defined as the senior leadership of the Clinical Enterprise who have significant strategic impact and a broad span of control with the ability to effect enterprise-wide change. Participants must be full-time employees of the University at the end of the Plan year to be eligible to receive an award for that Plan year, unless they have retired or involuntarily separated from the University as set forth in the Separation from the University provision below.~~

Eligibility to participate in CEMRP's LTI component is reserved for those senior executives who are in a position to make a significant impact on the achievement of long-term strategic objectives, specifically the EVP – UC Health and the CEOs at each of the Health Systems.

Plan participation in any one year does not provide any right or guarantee of eligibility or participation in any subsequent year of the Plan.

~~Participants must have at least a “Meets Expectations” overall rating on their performance evaluation for the Plan year to be considered for an award under the Plan. A manager may reduce an award according to the participant's overall performance rating. However, an overall performance rating below “Meets Expectations” will eliminate the total award for that participant.~~

~~A participant who has been found to have committed a serious violation of state or federal law or a serious violation of University policy at any time prior to distribution of an award will not be eligible for an award under the Plan. If such allegations against a participant are pending investigation at the time of the award distribution, the participant's award for that Plan year may be withheld pending the outcome of the investigation.~~

~~Likewise, when it has been determined that a participant's own actions or the participant's negligent oversight of other University employees played a material role in contributing to a serious adverse development that could harm the reputation, financial standing, or stability of the participant's Medical Center (e.g., the receipt of an adverse decision from a regulatory agency, placement on probation status, or the adverse resolution of a major medical malpractice claim), the AOC has the discretion to decide that the participant will either not be eligible for an award under the Plan that year or will receive an award that has been reduced as a result of and consistent with the participant's role with regard to the adverse development. If the participant's role with regard to the adverse development is still under investigation at the time of award distribution, the participant's award for the Plan year may be withheld pending the outcome of the investigation.~~

~~Prior to the beginning of the Plan year, the AOC will provide the President and the Chair of the Regents' Committee on Compensation with a list of Plan participants for that Plan year, including appropriate detail regarding each Plan participant.~~

~~Plan participation in any one year does not provide any right or guarantee of eligibility or participation in any subsequent year of the Plan.~~

Plan participants may be added after the Plan year has begun, subject to CEMRP's eligibility requirements and AOC approval.

Participants in this Plan may not participate in any other incentive or ~~bonus~~recognition plan during the Plan year, including the Health Sciences Compensation Plan, except in the event of a mid-year transfer within the University. Specifically, if a Plan participant is eligible for only a partial year award under this Plan because a mid-year transfer of position renders him or her eligible for Plan participation for only a portion of the Plan year, he or she may participate in a different University plan for the other portion of the Plan year. Concurrent participation in this Plan and another University incentive plan is not permitted.

CEMRP STI participants must have a minimum of six months of service to participate in the Plan and will receive a prorated award in their first year of participation. Similarly, participants who were not working for a significant portion of the Plan year may receive a prorated award in appropriate circumstances, as determined by the AOC. Participants who transfer within the University to a position that would not be eligible for participation in the Plan are eligible to receive a prorated award for that Plan year if they worked in the CEMRP-eligible position for at least six months.

An LTI participant hired or promoted into an LTI-eligible position between July 1 and December 31 of the Plan year will be assigned one or more long-term objective(s) for the three-year period that begins with the Plan year and will be eligible for a prorated LTI incentive opportunity for that period. The prorated LTI award will be determined by dividing the number of complete months employed during that three-year period by the number of months in the full performance period (36 months).

Prior to the beginning of the Plan year, the AOC will approve the Plan's participants and provide the President and the Chair of the Regents' Committee on Health Services with a list of participants for that Plan year, including appropriate detail regarding each participant.

7. AWARD OPPORTUNITY LEVELS

As part of their competitive total cash compensation package, Plan participants are assigned threshold, target and maximum incentive award levels, expressed as a percentage of their base salary. These award opportunity levels serve to motivate and drive individual and team performance toward ~~annually~~ established objectives. Target awards will be calibrated to expected results while maximum awards will ~~only~~ be granted only for superior performance against established performance standards. Actual awards for any individual participant may not exceed the maximum award opportunity level assigned. Award opportunity levels are determined, in part, based on the participant's level within the organization and the relative scope of responsibilities, impact of decisions, and long-term strategic impact. If a participant changes positions during the Plan year within the same institution (defined as the participant's ~~Medical Center~~Health System) and the participant's level within the organization changes based on the

table below, the participant’s award should be adjusted to take into account the amount of time spent in each position.

CEMRP STI Annual Award Opportunity (as percent of salary)

Position Level within Organization	Threshold Opportunity (as % of Salary)	Target Opportunity (as % of Salary)	Maximum Opportunity (as % of Salary)
<u>EVP – UC Health and Health System Chief Executive Officers</u>	10%	20%	30%
Other “Chief Levels” and Other Key Senior Clinical Enterprise Leadership	7.5%	15%	25%
Other Key Clinical Enterprise Leadership	7.5%	15%	20%

The individuals eligible to participate in CEMRP’s LTI component will be assigned one or more long-term performance objective(s) for the three-year period that begins with each new CEMRP Plan year, resulting in overlapping three-year LTI cycles. The LTI Threshold, Target, and Maximum award opportunity for the EVP – UC Health and the CEOs will be 5 percent, 10 percent and 15 percent, respectively, as shown in the chart below. The actual awards will be based on final assessments at the conclusion of the three-year LTI performance period and paid at the same time as the STI awards are paid.

CEMRP LTI Award Opportunity (as percent of salary)

<u>Position Level within Organization</u>	<u>Threshold Opportunity</u>	<u>Target Opportunity</u>	<u>Maximum Opportunity</u>
<u>EVP – UC Health and Health System Chief Executive Officers</u>	<u>5%</u>	<u>10%</u>	<u>15%</u>

8. PERFORMANCE STANDARDS

Each Plan participant will be assigned Performance Objectives which have standards of performance defined as Threshold, Target, and Maximum performance consistent with the following:

Threshold Performance – Represents the minimum acceptable performance standard for which an award can be paid. This level represents satisfactory results, but less than full achievement of stretch objectives.

Target Performance – Represents successful attainment of expected level of performance against stretch objectives.

Maximum Performance – Represents results which clearly and significantly exceed all performance expectations for the year. This level of accomplishment should be rare.

The same performance standards will be used for LTI performance objectives, but they will relate to performance over a three-year period rather than a one-year period.

9. PERFORMANCE OBJECTIVES AND WEIGHTINGS

Prior to the beginning of each fiscal year, a series of financial and non-financial performance objectives will be established for each participant, consistent with the mission and goals of the Clinical Enterprise and each Medical Center/Health System in the Clinical Enterprise.

~~There will nine objectives for each participant in the Plan comprised of the following: (1) Three objectives relating to the performance of the *Clinical Enterprise* (defined as Systemwide); (2) Three objectives relating to the performance of the *Institution* (defined as the participant’s Medical Center); (3) Three objectives relating to *Individual* performance. Each of the nine objectives will relate to one or more of the categories below:~~

- ~~● Financial Performance~~
- ~~● Quality Improvements~~
- ~~● Patient Satisfaction~~
- ~~● Key Initiatives in Support of the Strategic Plan~~
- ~~● People and other Resource Management~~

~~The participants’ performance toward their assigned objectives will be measured across three organizational levels as noted above (*Clinical Enterprise, Institutional, and Individual*) based on the weightings listed in the table below.~~

Position Level within Organization	Clinical Enterprise Level	Institutional Level	Individual Level
Chief Executive Officer	40%	40%	20%
Other “Chief Levels” and Other Key Senior Clinical Enterprise Leadership	30%	50%	20%
Other Clinical Participants	20%	50%	30%

~~Clinical Enterprise level (systemwide) objectives encourage medical centers/the Health Systems to work together for the benefit of the entire Clinical Enterprise system. Institutional performance objectives encourage local teamwork and recognize the joint effort needed to meet challenging organizational goals. Individual or departmental performance objectives are designed to encourage participants’ maximum effort and demonstration of focus attention on key individual excellence, or departmental initiatives.~~

For purposes of ~~the~~this Plan, ~~individual~~individual/departmental performance objectives should not be the same activities that are normal job requirements or expectations. Job performance is assessed as part of the Annual Performance Review Process. All CEMRP performance

objectives must be stretch in terms of achievement potential, must be aligned with specific Institutional and/or Clinical Enterprise initiatives, and are often peripheral but related to or integrated with ongoing job responsibilities.

Each of the STI and LTI performance objectives will relate to one or more of the categories below:

- Financial Performance
- Quality Improvements
- Patient Satisfaction
- Key Initiatives in Support of the Strategic Plan
- People and other Resource Management

There will be no more than nine STI performance objectives for each participant in CEMRP comprised of the following: (1) Up to three objectives relating to the performance of the *Clinical Enterprise* (defined as Systemwide); (2) Up to three objectives relating to the performance of the *Institution* (defined as the participant's Health System); (3) For all participants other than those eligible for the LTI component, up to three objectives relating to *Individual and/or Departmental* performance. If an Individual/Departmental performance objective has three components and the Threshold, Target, and Maximum performance standards are framed as "meet one of three," "meet two of three," and "meet three of three," respectively, each component must have equal importance and weighting. While this type of Individual/Departmental performance objective is permissible, Individual/Departmental performance objectives with clear metrics for each performance standard are preferred.

Annual STI Individual/Departmental performance objectives will be established and administered by each participant's supervisor in consultation with the CEO of that Health System for all participants other than those eligible to participate in the LTI component.

The annual STI Institutional performance objectives for each Health System will be established and administered by the EVP – UC Health in consultation with the respective Chancellors in advance of the Plan year.

The annual STI performance objectives for the Clinical Enterprise Level (systemwide) will be established by the President, who may consult with the Chair of the Regents' Committee on Health Services.

LTI participants will also be assigned one or more LTI performance objective(s) for each three-year performance period. The LTI performance objective(s) will require longer-term, multi-year efforts to achieve. LTI performance objectives must contain details that define Threshold, Target, and Maximum performance and include metrics and benchmarks, as appropriate. The LTI performance objectives will be established by the President, who will consult with the Chair of the Regents' Committee on Health Services.

All performance objectives must be SMART (specific, measurable, attainable, relevant, and time-based). Assessment of participants’ performance and contribution relative to these objectives will determine their actual award amount.

Peer group and/or industry data must be used where appropriate to provide a benchmark and performance standard. Performance objectives at the Clinical Enterprise and Institutional levels are typically measured against relative peer/industry benchmarks in the market. Where an established internal or external benchmark is used, baseline metrics must be included to enable a determination of the degree to which the intended results would require stretch performance. The Chief Human Resource Officer at each Health System will be responsible for ensuring that all Individual/Departmental objectives for participants at that location meet the SMART standards before obtaining sign-off from the CEO and Chancellor. The STI and LTI performance objectives for all participants will be subject to review and approval by the AOC prior to the beginning of the Plan year or as soon as possible thereafter. The AOC will consult the Senior Vice President – Chief Compliance and Audit Officer in an independent advisory capacity during its review of Plan participants’ objectives.

The participants’ performance toward their assigned STI objectives may be measured across three organizational levels as noted above (Clinical Enterprise, Institutional, and Individual/Departmental) and will be weighted according to the percentages listed in the table below.

Weighting of STI Annual Objectives

<u>Position Level within Organization</u>	<u>Clinical Enterprise Level</u>	<u>Institutional Level</u>	<u>Individual and/or Departmental Level</u>
<u>EVP – UC Health and Health System Chief Executive Officers</u>	<u>50%</u>	<u>50%</u>	<u>0%</u>
<u>Other “Chief Levels” and Other Key Senior Clinical Enterprise Leadership</u>	<u>30%</u>	<u>50%</u>	<u>20%</u>
<u>Other Clinical Participants</u>	<u>20%</u>	<u>50%</u>	<u>30%</u>

The supervisor of each Plan participant will provide him/her with: (a) the participant’s performance objectives for the Plan year, (b) the performance standards that will be used to measure Threshold, Target, and Maximum performance for each objective, (c) the performance weightings that will apply to the participant’s performance objectives, and (d) a copy of this Plan document.

~~Annual performance objectives for the Clinical Enterprise Level (system-wide), annual Institutional performance objectives for each medical center, and annual performance objectives for the individual CEOs of the medical centers will be established and administered by the Senior Vice President – Health Sciences and Services in consultation with the respective Chancellors in advance of the Plan year. Annual performance objectives for the Senior Vice President – Health Sciences and Services will be established by the President in consultation with the Chairs of the Regents’ Committees on Compensation and Health Services in advance of~~

~~the Plan year. Annual performance objectives for other participants will be established and administered by each participant's supervisor in consultation with the CEO of that medical center.~~

~~Objectives for participants in this Plan must be submitted to the AOC, which will review and approve the objectives in consultation with the President and the Chairs of the Regents' Committees on Compensation and Health Services in advance of the Plan year. The AOC will consult the Senior Vice President—Chief Audit and Compliance Officer in an independent advisory capacity during its review of Plan participants' objectives.~~

10. FINANCIAL STANDARDS AND PLAN FUNDING

~~A financial target will be set by each medical center for the Plan year. These financial targets will be reviewed by the AOC in consultation with the Senior Vice President—Health Sciences and Services and the Executive Vice President and Chief Financial Officer, and approved by the President in advance of the beginning of the Plan year.~~

~~Full funding of incentive STI awards for participants at a medical center Health System in the Plan year is contingent upon that medical center's Health System's ability to pay out the awards while maintaining a positive net cash flow from operations before intra-institutional transfers. In the event that the medical center Health System cannot meet that financial standard for the Plan year, and the medical center Health System attains key Institutional non-financial objectives, the AOC may consider and approve, in consultation with the Chancellor and ~~Senior Vice President—EVP – UC Health Sciences and Services~~, partial incentive STI award payouts for some or all of that medical center's Health System's Plan participants based on the Award Opportunity Levels defined above and participants' achievement of their assigned STI performance objectives for the Plan year.~~

11. INCENTIVE AWARD ELIGIBILITY CRITERIA

Participants must be active full-time employees of the University at the conclusion of the Plan year (i.e., as of midnight on June 30th) to be eligible to receive an STI award for that Plan year, unless the circumstances of their separation from the University entitle them to a full or partial award as set forth in the Separation from the University provision below in Section 13.

LTI participants must be active full-time employees at the conclusion of the three-year period associated with an LTI performance objective (i.e., as of midnight on June 30th of the third year) to be eligible to receive an LTI award for that period.

Participants must have at least a “Meets Expectations” or equivalent overall rating on their performance evaluation for the Plan year to be considered for an STI award under the Plan for that Plan year or an LTI award for the performance period that concludes at the end of that Plan year. A manager may reduce or eliminate an award according to the participant's overall performance rating with the approval of the AOC. However, an overall performance rating below “Meets Expectations” will eliminate the total award for that participant for that Plan year or performance period.

A participant who has been found to have committed a serious violation of state or federal law or a serious violation of University policy at any time prior to distribution of an STI or LTI award will not be eligible for such awards under the Plan for that Plan year and/or performance period. If such allegations against a participant are pending investigation at the time of the award distribution, the participant's award(s) may be withheld pending the outcome of the investigation. If the participant's violation is discovered later, the participant may be required to repay awards for the Plan years and/or performance periods in which the violation occurred.

Likewise, when it has been determined that a participant's own actions or the participant's negligent oversight of other University employees played a material role in contributing to a serious adverse development that could harm the reputation, financial standing, or stability of the participant's Health System (e.g., the receipt of an adverse decision from a regulatory agency, placement on probation status, or the adverse resolution of a major medical malpractice claim) or, with regard to the EVP – UC Health, the Clinical Enterprise overall, the AOC has the discretion to decide that the participant will either not be eligible for an STI or LTI award under the Plan that year or will receive an award that has been reduced as a result of and consistent with the participant's role with regard to the adverse development. If the participant's role with regard to the adverse development is still under investigation at the time of award distribution, the participant's award for the Plan year may be withheld pending the outcome of the investigation.

If the participant's role in the adverse development is discovered later, the participant may be required to repay awards for the years in which the actions or negligent oversight occurred.

ADMINISTRATIVE PROVISIONS AND INCENTIVE AWARD APPROVAL

~~The Plan will be administered under the purview of the Executive Director— Compensation Programs and Strategy, at the Office of the President, consistent with the Plan features outlined above, and as approved by the President and the Regents. The Plan features and provisions outlined in this document will supersede any other Plan summary.~~

12. INCENTIVE AWARD APPROVAL PROCESS

~~The supervisor of each Plan participant will provide him/her with an annual Terms and Conditions document that (a) identifies the participant's individual performance objectives for the Plan year, (b) defines the standards that will be used to measure Threshold, Target, and Maximum performance for each objective, and (c) indicates the performance weightings that will apply to the participant's individual objectives.~~

~~At the end of each fiscal Plan year, proposed incentive awards will be submitted to the Executive Director – Compensation Programs and Strategy. Except as set forth below, review and approval of all incentive awards under the Plan will be the responsibility of the AOC, which will review recommended incentive awards within 60 days of the end of the Plan Year. awards amounts will be reviewed and approved by the AOC. Any incentive award for the Senior Vice President— Health Sciences and Services or any other Plan participant who holds one of the executive offices identified in section 92032(b)(7)(B)(i) of the California Education Code, including, but not limited to, any vice president of the University, EVP – UC Health will require the approval of~~

~~the Regents~~ Regents' Committee on Health Services in addition to the approval of the AOC. The AOC will consult the Senior Vice President – Chief Compliance and Audit Officer in an independent advisory capacity during its review of proposed incentive awards. The AOC will provide the chair of the Regents' Committee on Health Services and the President with a listing of award recommendations before awards are scheduled to be paid. On behalf of the AOC, the Executive Director – Compensation Programs and Strategy will provide the President and the Regents with the award details in the Annual Report on Executive Compensation.

Approved incentive awards will be processed as soon as possible unless they have been deferred pursuant to the provision set forth below. ~~The AOC will consult the Senior Vice President – Chief Audit and Compliance Officer in an independent advisory capacity during its review of proposed incentive awards.~~

~~The Executive Director – Compensation Programs and Strategy will provide the President and Chairs of the Regents' Committees on Compensation and Health Services with a listing of the incentive award recommendations before the awards are scheduled to be paid. The awards will be reported annually to the Regents, with appropriate detail, such as the range of awards, and the percentage and amount of the award granted for each Plan participant.~~

Annual incentive awards will be payable in cash, subject to appropriate taxes and pursuant to normal University payroll procedures. The participant's total University salary (~~including which includes~~ base salary, and any stipends, and PTO pay, but excluding ~~does not include~~ any prior year incentive award payouts and/or disability pay) paid as of the end June 1st of the Plan year (i.e., on June 30) ~~will be used in the calculation of the incentive award payout amount. The assigned Description of Service code of "XCE" specific to the Plan must be used when paying awards to Plan participants.~~

This Plan may be terminated or replaced at any time for any reason upon the recommendation of the President, in consultation with the ~~Chairs~~ Chair of the Regents' ~~Committees~~ Committee on ~~Compensation and Health Services, and with the approval of the Regents.~~ Reasonable efforts, given all circumstances, will be made to delay Plan termination until after the current Plan year has concluded. However, if the Plan is terminated during the Plan year, awards for the current year will still be processed based on participants' performance during the portion of the Plan year prior to termination.

Notwithstanding any other term in the Plan, current year incentive awards may be deferred if the Regents issue a declaration of extreme financial emergency upon the recommendation of the President or if the Clinical Enterprise experiences a ~~system-wide~~ systemwide negative cash flow. In such situations, the deferral would be made upon the recommendation of the AOC and require the approval of the President and the ~~Chairs~~ Chair of the Regents' ~~Committees~~ Committee on ~~Compensation and Health Services.~~ In such a case the current year deferred awards will earn interest at the ~~STIP~~ Short Term Investment Pool rate. Award payments that have been approved, but deferred, will be processed and distributed as soon as possible. In no event will awards be deferred longer than one year.

The University may require repayment of an award that ~~has been~~was made as a result of inappropriate circumstances. For example, if there is an inadvertent overpayment, the participant will be required to repay the overage. If the participant has not made the repayment before an award for the employee for a subsequent Plan year is approved, the outstanding amount may be deducted from the employee's subsequent award.

13. SEPARATION FROM THE UNIVERSITY

~~Participants~~The table below indicates whether a participant who ~~retire or who involuntarily separate due to reorganization, restructuring, or total disability during the current Plan year~~ separates from the University will be eligible to receive a prorated incentive full or partial STI award for the current Plan year based on the date and also specifies when forfeiture of separation of employment from the University such awards will occur. Retirement and total disability status will be determined based upon applicable University policies. In order to determine the most accurate STI award for the current Plan year, ~~prorated~~prorated partial payments will be calculated at the end of the Plan year and issued in accordance with the normal ~~processing process and~~ processing process and schedule.

~~Participants whose employment terminates as a result of death during the current Plan year are similarly eligible to receive a prorated incentive award for the current Plan year based on the date of death. In this situation, award payments will be made to the estate of the deceased participant. In order to determine the most accurate award for the current Plan year, prorated payments will be calculated at the end of the Plan year and issued to the estate of the deceased participant in accordance with the normal processing schedule.~~

~~Involuntary separation during the current Plan year for any other reason will be handled on a case by case basis.~~

PARTIAL YEAR INCENTIVE AWARDS

~~Participants must have a minimum of six months of service to participate in the Plan and will receive a prorated award in their first year of participation. Similarly, participants who were not working for a significant portion of the Plan year may receive a prorated award. Participants who transfer within the University to a position that would not be eligible for participation in the Plan are eligible to receive a prorated award for that Plan year.~~

<u>Reason for Separation</u>	<u>Separation During Plan Year (i.e., on or before June 30, 2017)</u>	<u>Separation on or after July 1, 2017</u>
<u>Voluntary Separation for any reason other than retirement</u>	<ul style="list-style-type: none"> • <u>Forfeiture of STI award for 2016-17 Plan year.</u> 	<ul style="list-style-type: none"> • <u>Payout of full STI award for 2016-17 Plan year.</u>
<ul style="list-style-type: none"> • <u>Retirement</u> • <u>Medical separation due to disability</u> • <u>Death*</u> • <u>Involuntary separation due to reorganization or restructuring</u> 	<ul style="list-style-type: none"> • <u>Partial STI award for 2016-17 Plan year.</u> 	<ul style="list-style-type: none"> • <u>Payout of full STI award for 2016-17 Plan year.</u>
<u>Involuntary termination due to misconduct or inadequate performance</u>	<ul style="list-style-type: none"> • <u>Forfeiture of STI award for 2016-17 Plan year.</u> 	<ul style="list-style-type: none"> • <u>Forfeiture of STI award for 2016-17 Plan year.</u>

*In such cases, payments will be made to the estate of the participant.

LTI awards are not eligible for full or partial payment if a participant separates from the University before the conclusion of the applicable three-year LTI performance period; forfeiture will occur.

14. TREATMENT FOR BENEFIT PURPOSES

~~With the exception of the Senior Management Supplemental Benefit Program, incentive~~ Incentive awards under this Plan are not considered to be compensation for University benefit purposes, such as the University of California Retirement Plan or employee life insurance programs.

15. TAX TREATMENT AND REPORTING

Under Internal Revenue Service Regulations, payment of incentive awards under this Plan must be included in the participant's income as wages subject to withholding for federal and state income taxes and applicable FICA taxes. The payment is reportable on the participant's Form W-2 in the year paid.