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Key Nonprofit Corporate Law Developments in 2010



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The year 2010 witnessed an extraordinary series of developments in nonprofit corporate and charitable trust law as they affected the governance and operation of hospitals and health care systems. This is consistent with a decade-long trend that has made corporate law and governance key legal feasibility considerations for nonprofit organizations.

These developments reflect the following general trends: (a) increased oversight from state and federal charity regulators; (b) greater focus on corporate governance practices; (c) closer scrutiny of the exercise of

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business judgment by boards; (d) the evolution of system structures and business combinations; (e) the governance implications of an economy in transition; and, notably, (f) the challenges and opportunities arising from the March, 2010, enactment of the Patient Protection and Affordable Care Act (PPACA).

Based on these trends, our “top ten” list of major nonprofit corporate law developments for health care providers in 2010 is as follows:

1. Health Reform and the Board

Perhaps the most compelling development of the year was the health care reform-related expectations of the nonprofit hospital board. The PPACA offers the potential for prompting the most significant impact on the health care financing system since the adoption of Medicare in 1965. By their actions, Congress and the Obama administration essentially handed hospital/health system boards an enormous “home-work assignment,” the likes of which boards have not previously confronted. These boards have thus been presented with an unprecedented fiduciary challenge, to which they are expected by health care and charity regulators to respond both swiftly and effectively.

The board thus must be “front and center” as the effects of the reform legislation are realized within the hospital and throughout the health system. Board members are expected to demonstrate an enhanced duty of care as they work with management to evaluate the strategic implications of health care reform and determine responsive strategies. Such a close management/board collaboration can have highly positive effects, not only in terms of a coherent strategic direction but also in terms of the organization's credit rating.¹

¹ The favorable relationship between capable and engaged corporate governance and a nonprofit hospital's credit rating

The board also must recognize a particularly acute need to respond to specific reform-driven transactional opportunities as presented by management. For example, the board must be prepared to evaluate strategies designed to establish a clinically and financially integrated delivery system. Pressure to create such systems is arising from both internal and external sources, as the PPACA operates to control costs and improve quality in the health care system through new statutory incentives for the creation of state-of-the-art delivery system models such as accountable care organizations (ACOs) and medical homes. The board also is expected to evaluate hospital merger/acquisition opportunities and needs, as reform-prompted integration activity between hospitals is at near record levels in many markets across the country.

Other hospital governance issues prompted by the PPACA include (a) special conflicts of interest concerns involving physician directors (particularly in connection with the consideration of ACOs and other physician integration strategies); (b) the adequacy of information flow from management to the board; (c) the accessibility to the board of senior management and advisers; (d) the proper degree of reliance by the board on management and advisers; and (e) governance implications of hospital investments/participation in physician integration vehicles.

The PPACA itself contains no provisions addressing corporate law and governance. Yet, the magnitude of its breadth and influence promises profound implications for the structure and scope of nonprofit hospital governance. It provides an extraordinary opportunity for the board to play a truly significant role in charting the organizational future. In many respects, the PPACA offers the ultimate “teachable moment” with respect to the proper roles and relationships between the governance and management of nonprofit hospitals.

☒ The extent to which the board asserts an informed, proactive leadership role on health care reform issues will have a substantial impact on the ability of the nonprofit hospital/health system to successfully address PPACA-related challenges and opportunities. Accordingly, the board is expected to maintain full engagement with organizational reform-related strategies in 2011.

2. Tax Compliance

2010 included a significant increase in federal tax exemption developments from recent years, including adoption of new supplemental requirements for hospital federal tax exempt status, and a notably more active IRS with respect to tax compliance matters. These developments reflected the influence of health care reform, the continued IRS interest in exempt organization governance, and a special focus on the tax exempt organizations compliance challenges of an economy in transition. Indeed, in an Oct. 19 speech, IRS Director of Exempt Organizations Lois Lerner referred to tax exempt status as a ‘huge gift’ given to organizations by the public²—a comment which underscores the IRS’s interest in compliant organizational behavior.

was emphasized by Moody’s Investors Service in its Dec. 20, 2010, Special Comment, “Governance and Management of Not-for-Profit Healthcare Organizations: A Key Driver of Ratings” (subscription only).

² 201 DTR G-4 (10/20/10).

One of the most notable 2010 tax developments was the adoption through the PPACA of I.R.C. Sec. 501(r), adding four new, supplemental requirements for hospital tax exempt status.³ These new requirements serve to supplement the existing exemption standards under I.R.C. Sec. 501(c)(3). Failure to satisfy the new requirements could result in loss of tax-exempt status at either the entity level or at the hospital-specific level, and a \$50,000 penalty for failure to comply with the community health needs assessment requirement. Accordingly, the new requirements become a significant board-level compliance oversight concern. This is particularly the case as the current congressional deficit-reduction dialogue can be expected to examine the value of entitlements, such as tax exemptions to a particular industry sector. These supplemental requirements are the by-product of a near decade-long legislative and public scrutiny of the IRS’s long-standing “Community Exempt Standard” of hospital tax exempt status.⁴ Questions with respect to 501(r) compliance are expected to be included in the Form 990 for 2010, given the March 23, 2010 effective date of Sec. 501(r).⁵

A related PPACA development confronting hospitals and health systems in 2010 was tax exemption-related planning for participation in ACOs and similar integrated organizations. Key planning issues included whether an ACO entity may qualify for tax-exempt status on a “stand alone” basis; whether a tax-exempt hospital may participate in an ACO on a joint venture basis and, with respect to both stand alone and joint venture ACOs, the structural standards that should govern a hospital’s participation in such entities consistent with its own tax exempt status. Guidance from the IRS on these and related issues is not expected in the immediate future.

Another notable development was the December, 2010, publication of the IRS’s Exempt Organization Workplan for FY 2011.⁶ The workplan provides useful data on trends in exempt organization audit activity and projected audit focus highly relevant to tax exempt hospitals. For example, the workplan notes that the volume of “traditional” (i.e., “boots on the ground”)

³ The additional requirements include those relating to (a) periodic conduct of a “Community Health Needs Assessment” and the adoption of an implementation strategy to meet the needs identified in the Assessment; (b) establishment of a financial assistance policy and a policy relating to emergency medical care; (c) limitations on amounts charged for emergency care provided for individuals eligible for assistance under the hospital’s financial assistance policy; and (d) forgoing extraordinary collection practices against individuals until the hospital has made reasonable efforts to determine whether an individual is eligible for assistance under the hospital’s financial assistance policy. The IRS currently is in the process of finalizing proposed regulations that will implement the new supplemental requirements.

⁴ See, e.g., remarks of Steven T. Miller, then-commissioner of tax exempt and governmental entities, Internal Revenue Service, “Community Benefit and Nonprofit Hospitals”, before the Office of the Attorney General of Texas Charitable Hospitals: Modern Trends, Obligations and Challenges, Jan. 12, 2009, Austin, Texas, http://www.irs.gov/pub/irs-tege/miller_speech_011209.pdf.

⁵ See, e.g., The Exempt Organization Tax Review, Vol. 66. No. 5, p. 449 (November 2010).

⁶ Exempt Organizations Division FY 2010 Annual Report and FY 2011 Workplan. http://www.irs.gov/pub/irs-tege/fy2011_eo_workplan.pdf.

examinations—as opposed to “compliance checks”—has almost *doubled* since 2004. The number of Exempt Organizations Division employees participating in audit/examination activity has increased from 450 in FY 2008 to approximately 550 in FY 2010, an 18 percent increase. The percentage of exempt organization returns examined by the IRS has more than doubled over the last nine years, from 0.61 percent in FY 2001 to 1.47 percent in FY 2010. While not specific to tax exempt hospitals, the statistics are worthy of their attention as they demonstrate materially increased audit activity involving tax exempt organizations.

The workplan also highlights the IRS’s continued commitment to exempt organization oversight by identifying a series of compliance initiatives of particular interest to tax exempt hospitals and health systems.⁷ These initiatives include, but are not limited to, compliance with organizational employment tax obligations; tax issues associated with loans made to officers, directors, trustees and key employees; informational inquiries intended to develop a better understanding about sources and uses of funds in the charitable sector and their relationship to exempt purposes; and use of the Form 990 as a compliance tool to identify noncompliant and potentially noncompliant organizations for examination, to develop targeted compliance projects, and to inform and support tax compliance educational efforts.

In addition, the IRS expects to use data on exempt organization governance practices derived from application of its governance “check sheet”⁸ to provide IRS with a better understanding of the “intersection” between governance practices and tax compliance. This initiative underscores the relevance of effective corporate governance to preservation of tax exempt status.

☒ The cumulative effect of these legislative developments and oversight initiatives is that the IRS remains meaningfully committed to audit and enforcement activity in the tax exempt sector. The referenced priority guidance and enforcement activity provide nonprofit hospitals with tangible evidence of the significant and evolving areas of IRS tax exemption focus. This should be of great interest to nonprofit hospital executives and compliance officers in 2011.

3. “M&A” Activity

Transactional activity involving nonprofit hospitals increased dramatically in 2010, principally in reaction to market-based challenges arising from PPACA implementation. This activity has, in turn, prompted greater regulatory focus on the reasonableness of individual transactions, and the business judgment exercised by boards in the transaction oversight process.

The PPACA fundamentally changed the operating landscape for nonprofit hospitals, health systems and academic medical centers, prompting them to re-examine their strategies for achieving their core missions. A key question is whether individual providers possess the size, scale, and market position to meet the new demands imposed upon them by health care reform initiatives. In doing so, many have recognized that growth and scale are critical to meeting the new reform-related cost, quality and reporting obligations. Increased 2010 merger activity thus reflects the fact that an important aspect of an institution’s strategy has be-

come the active consideration of mergers, acquisitions, member substitutions, joint ventures, and clinical affiliations with other hospitals, health systems and academic medical centers. Along these lines, Moody’s Investors Service rating agency has commented favorably on the credit rating implications of a merger/acquisition strategy.⁹

However, 2010 developments also reflect the fact that organic corporate transactions involving nonprofit hospitals typically are heavily regulated by the states. This is particularly (but not exclusively) the case in transactions where nonprofit assets are transferred to for-profit ownership. For example, three of the most significant 2010 transactions involved sales of nonprofit hospitals to large proprietary chains: private equity firm Cerberus Capital Management’s purchase of nonprofit Caritas Christi Healthcare System (Boston); for-profit Vanguard Health’s purchase of Detroit Medical Center; and for-profit Community Health System’s purchase of Forum Health (Youngstown, Ohio). The Caritas Christi and Detroit Medical Center acquisitions both were the subject of a significant state attorney general approval process.¹⁰ Broad anecdotal evidence suggests a level of close state review of board conduct in all types of M&A transactions involving nonprofit hospitals, even those involving only nonprofit parties and those that are not subject to specific statutory requirements (e.g., a nonprofit hospital conversion statute).

The close state level scrutiny of nonprofit M&A transactions also was sharply illustrated by the May 21, 2010, decision of the New Hampshire attorney general to oppose (on charitable trust and other grounds) the proposed corporate affiliation between Dartmouth-Hitchcock Health and CMC Healthcare System.¹¹ One of the principal concerns of the attorney general was that judicial approval would be necessary to authorize the “profound change” to the CMC governance structure and religious-oriented mission that would result from the proposed transaction.

Another example of state oversight was the May, 2010, advisory opinion of Colorado Attorney General John Suthers that the proceeds from a sale of municipally owned Colorado Springs Memorial Health System to a for-profit health care entity would be required to be used for a similar charitable activity (meaning that the proceeds could not be applied to the city’s general fund)¹² in accordance with the state’s Hospital Transfer Act. This is of interest given that many municipal hospitals—including those organized through nonprofit ownership—are considering change of ownership options as a revenue generation device.

Other notable 2010 “M&A” developments reflected the inherent volatility of complex nonprofit hospital affiliations and similar transactions. For example, litigation continues in connection with the terms of the withdrawal of Massachusetts-based New England Medical

⁹ See Moody’s Investors Service, “Major M&A Activity Among Not-for-Profit Hospitals is Favorable,” Oct. 11, 2010 (subscription only).

¹⁰ See, e.g., www.mass.gov/ago/caritas; http://www.michigan.gov/documents/ag/Attorney_General_DMC_Report_338410_7.pdf.

¹¹ <http://doj.nh.gov/publications/nreleases2010/052110.html>.

¹² See, e.g., <http://thefutureofhealthcare.com/suthers-transfer-act-applies-to-memorial/>.

⁷ *Id.*

⁸ <http://www.irs.gov/charities/article/0,,id=216068,00.html>.

Center (NEMC) from LifeSpan Corp., a Delaware nonprofit health system. The Massachusetts attorney general has intervened on NEMC's side to join most of the counterclaims against LifeSpan. The most significant 2010 development in the case was the July 20 decision of the federal district court that granted partial summary judgment to both sides, concluding that (a) LifeSpan owed a fiduciary duty to NEMC during their affiliation but that NEMC had released its related claims in their separation agreement in exchange for a broad indemnification provision; and (b) that the Massachusetts attorney general—which was not a party to the disaffiliation agreement—had an independent authority to pursue a breach of fiduciary duty claim against LifeSpan, even if the claim had been released by NEMC.¹³ The district court also ruled in September, 2010, that no statute of limitations applies to the attorney general's fiduciary duty enforcement, agreeing with the attorney general's brief with respect to the similarities between charitable corporations and charitable trusts.¹⁴

The tension between “conversion foundations” and for-profit hospital purchasers was demonstrated in litigation filed by the Health Care Foundation of Greater Kansas City against HCA Inc. (and other parties) with respect to the terms of the capital improvement and charity care commitments included in connection with HCA's 2002 purchase of several hospitals from nonprofit Health Midwest.¹⁵

☒ These 2010 developments carry great significant for nonprofit hospitals, as merger/acquisition activity in this sector is expected to substantially increase in 2011. They offer useful structuring, drafting and operational guidance for hospitals considering a merger/acquisition or similar transaction in 2011.

4. Fiduciary Duty

A series of noteworthy 2010 developments provide a potent reminder that while case law continues to support generous application of the business judgment rule to nonprofit director conduct, it will not provide “bullet proof” protection in matters of involving alleged wrongful conduct that goes substantially beyond negligence, e.g., conscious inattentiveness, financial impropriety, self-dealing, or waste of assets.

For example, on Jan. 15, 2010 the New Jersey attorney general and nonprofit Stevens Institute agreed to adopt a series of corporate governance changes to settle a 16-count civil complaint filed by the attorney general in September, 2010, alleging that the institution, its president and its board chair mismanaged its finances and endowment and excessively compensated its president.¹⁶ (The entire board of trustees was included as “John Doe” defendants in the civil action.) The corporate governance changes instituted in the settlement related to board composition and practices and commit-

tee structure. They were referred to as “best in class” by the attorney general's office and as an example to other not-for-profit organizations.

The *Stevens* controversy reflects (1) the willingness of state officials to challenge board action they perceive as placing charitable assets at risk; (2) the specific type of board conduct that may attract regulatory inquiry; and (3) the breadth of relief (including governance reforms) potentially available to state charity officials to correct problematic practices. It also represents the most recent notable state charity official enforcement action of UMIFA/UPMIFA principles.

In two other 2010 instances, a controversy between a reputable nonprofit health care organization and its CEO served to shine a bright (and unfavorable) light on the subject of board oversight of senior management, and board responsiveness to suspicious conduct or events. Both instances fueled intense media scrutiny and prompted an internal legal investigation of the underlying facts. One (Kansas City University of Medicine and Biosciences) related to allegedly questionable CEO expenditures and other management practices and ultimately spawned competing litigation complaints filed by the board and the CEO, respectively.¹⁷ The other (Boston's Beth Israel Deaconess Medical Center) involved a state attorney general review of the board's response to whistleblower allegations concerning the CEO, the results of which review were made publicly available.¹⁸ Both instances resulted in significant financial and reputation damage to the involved institutions and individuals. Most notably, in both instances a concern was raised that warning signs allegedly were presented to individual board members (if not the full board) long before events prompted the full board to commence an investigation.

Indeed, in its findings, the Massachusetts attorney general commented that the organization's reputation is a charitable asset which should be protected by the board. Further, the attorney general was critical of what it described as excessive deference on the part of board members to the CEO in light of his record of exemplary administrative performance; i.e., a lack of independent board oversight.¹⁹ However, it is important to note that no specific liability was sought by the attorney general against these individuals.

Developments from the larger nonprofit sector also provided examples of government oversight of nonprofit board conduct. For example, allegations of lax board oversight were lodged in connection with the Senate Finance Committee's probe of the prominent charity, Boys and Girls Clubs of America.²⁰ Specific focus was made on executive compensation, executive perquisites, executive retirement plans and lobbying expenses of the national umbrella organization. The committee also requested broader operational and program accomplishment information from the organization. On May 24, the California attorney general filed a civil complaint against Monterey County AIDS Project and several of its officers, directors, and key employees.

¹³ *LifeSpan Corp. v. New England Medical Center, Inc.*, 2010 U.S. Dist. LEXIS 74659 (D.R.I. July 20, 2010). The trial of the case is scheduled for Feb. 14, 2011. The matters that will be litigated (in addition to the fiduciary breach issue) will include NEMC's claims against LifeSpan for gross negligence, willful malfeasance, and misrepresentation.

¹⁴ 2010 WL 3718952.

¹⁵ <http://www.bizjournals.com/kansascity/stories/2009/10/12/story13.html>.

¹⁶ <http://www.nj.gov/oag/newsreleases/10/pr20100115b.html>.

¹⁷ See, e.g., <http://www.bizjournals.com/kansascity/stories/2010/03/29/story1.html>

¹⁸ http://www.mass.gov/Cago/docs/nonprofit/Beth_Israel_Hospital_Review_090110.pdf.

¹⁹ *Id.*

²⁰ <http://finance.senate.gov/newsroom/ranking/release/?id=d7e3ea3d-1e61-49cb-9ccb-ee4874c032cf>.

The complaint focused on allegations that over \$2.8 million of charitable assets were “misappropriated, misapplied or wasted.” Much like the Stevens Institute case, the Monterey County complaint served as a virtual “primer” on the scope of possible breach of fiduciary duty claims. Specific allegations included improper diversion of charitable assets, failure to use assets for a restricted purpose, failure to take actions to recover improperly diverted funds, and negligence.²¹ Also of interest was the review commenced by the Pennsylvania attorney general of the propriety of the Hershey Trust’s \$12 million purchase and renovation of a golf course adjacent to the Milton S. Hershey School.²²

A further example of state regulatory action was Kentucky Gov. Steve Beshear (D)’s December intervention to restructure the corporate leadership of nonprofit Passport Health Plan.²³ Passport is a nonprofit entity formed 13 years ago with state guidance by leading Jefferson County, Ky., providers as a means of controlling Medicaid costs through managed care covered by the program. Concerns had arisen with alleged management-level conflicts of interest, excessive travel and lobbying expenses, and questionable transfers of surplus funds from Passport to its founding providers.²⁴

A March, 2010, decision of the North Carolina Business Court provided an extensive discussion of directors’ fiduciary duties under North Carolina and Delaware law, including such key issues as (a) the standard of conduct v. the standard of review in corporate governance cases; (b) whether “good faith” is an independent duty; and (c) whether director duties are to be judged contextually.²⁵

A December decision of the Tennessee Supreme Court dealt a further blow to the concept that corporate directors owe a special fiduciary duty to creditors in the “zone of insolvency,” holding that corporate creditors already are adequately protected by existing law.²⁶ This decision is particularly noteworthy given the increase in bankruptcies and insolvencies amongst nonprofit hospitals.²⁷

☒ 2010 reflected close legislative and regulatory scrutiny of allegedly problematic nonprofit board conduct, and a willingness of legislators and regulators to bring civil challenges in perceived egregious circumstances. This level of activity can be expected to continue in 2011 as charity regulators monitor the impact of the PPACA on nonprofit hospitals and their assets.

5. Executive Compensation

Regulatory/legislative focus on nonprofit executive compensation arrangements significantly increased in 2010. Emphasis on the determination of “reasonableness,” the proper role of the compensation committee, and the continued utility of the “rebuttable presumption of reasonableness” continued during the year. Media

stories— often prompted by Form 990 publication— regularly (if often inaccurately) proclaimed concern with perceived nonprofit compensation excesses. This concern was exacerbated by compensation imbalances perceived as arising from the recessionary economy.

A significant development with potential 2011 implications was the examination of compensation trends in the nonprofit sector published in the Oct. 5, 2010, edition of the *Chronicle of Philanthropy*.²⁸ In particular, the *Chronicle*’s survey suggested the potential for public, media, and regulatory “pushback” as retirement and deferred compensation arrangements approved prior to the economic recession began to be disclosed on the Form 990. The implicit concern was whether the aggregate value of such compensation arrangements would appear “excessive” to third parties in the context of the current economic and political environment.

Regulatory oversight of nonprofit compensation arrangements was reflected in a series of high-profile 2010 developments. For example, in June, the New Hampshire attorney general began a review of executive compensation arrangements of nonprofit hospitals in the state.²⁹ The review was prompted in part by the attorney general’s findings on executive compensation in the Dartmouth-Hitchcock affiliation (see above). This led to the decision to review similar compensation arrangements at other nonprofit hospitals. On July 2, the Vermont insurance commissioner ordered nonprofit Blue Cross Blue Shield of Vermont to return \$3 million in premium refunds to subscribers to conclude the Commissioner’s investigation into the allegedly excessive compensation paid to the organization’s former CEO.³⁰ The Senate Finance Committee’s review of nonprofit Boys and Girls Clubs included an executive compensation component.³¹ These and other similar initiatives reflected a willingness of regulators to “look behind the numbers” and examine the specifics of comparability data, among other factors in the compensation determination process.

A noteworthy development with special significance to nonprofit health care was the May release of the IRS’s Interim Report on its Colleges and Universities Compliance Project.³² The interim report was based upon data provided pursuant to a compliance check questionnaire distributed in 2008 to over 400 public and private colleges. A significant portion of the interim report analyzed data submitted in response to the executive compensation questions presented in the questionnaire. These questions were of greater scope and sophistication than those contained in the compliance check questionnaire previously submitted to the nonprofit hospital sectors as part of the IRS’s prior Hospital Industry Compliance Project. The IRS’s data reflects

²¹ http://ag.ca.gov/cms_attachments/press/pdfs/n1924_complaint.pdf.

²² <http://www.post-gazette.com/pg/10355/1112323-454.stm>.

²³ Loftus, “Gov. Steve Beshear demands immediate house-keeping at Passport,” <http://www.courier-journal.com/apps/pbcs.dll/article?AID=2010312210084>, Dec. 21, 2010.

²⁴ *Id.*

²⁵ *State v. Custard*, http://www.ncbusinesscourt.net/opinions/2010_NCBC_6.pdf.

²⁶ *Sanford v. Waugh & Co.*, 2010 Tenn. LEXIS 1151 (Tenn. Dec. 17, 2010).

²⁷ *Id.*

²⁸ Ben Gose, “Nonprofit Executives Pay Stalls as Bad Economy Lingers” *The Chronicle of Philanthropy*, Oct. 3, 2010.

²⁹ Mark Hayward, “Hospitals defend high pay of their CEOs,” *New Hampshire Union Leader*, June 15, 2010.

³⁰ Press release, State of Vermont Department of Banking, Insurance, Securities & Health Care Administration June 2, 2010 (www.bishca.state.vt.us).

³¹ Press Release, Senate Finance Committee, March 12, 2010, <http://finance.senate.gov/newsroom/ranking/release/?id=d7e3ea3d-1e61-49cb-9ccb-ee4874c032cf>.

³² IRS Releases Interim Report on Nonprofit Colleges and Universities Compliance Project, May 7, 2010 <http://www.irs.gov/newsroom/article/0,,id=222656,00.html>.

progress made by exempt organizations (such as colleges and universities) in the quality of their executive compensation board oversight. While the data did not reflect unusually high average annual CEO compensation, neither did it reflect uniform satisfaction of the rebuttable presumption of reasonableness safe harbor. The forthcoming final report from the IRS can be expected to identify compensation-related issues and areas that warrant additional guidance and further scrutiny, and as such may likely have an indirect application to other tax-exempt organizations such as health care organizations.

Continued pressure on the sustainability of the rebuttable presumption of reasonableness was reflected in public concerns that the process served to artificially increase compensation through excessive reliance on comparability. Indeed, Sen. Charles Grassley (R-Iowa) unsuccessfully attempted to amend it (essentially to make the process a required governance practice but not to create a rebuttable presumption) as part of the PPACA legislative debate.³³ Of course, the RPR is not binding on state charity reviews of executive compensation.

Certain federal legislative developments introduced in 2010 into the public discourse a series of executive compensation practices previously considered extreme. The Troubled Asset Relief Program and Dodd-Frank Wall Street Reform and Consumer Protection Act law (and related SEC rulemaking) contained provisions addressing compensation ceilings, “clawbacks,” limitations on golden parachutes, and risk-based compensation limitations.³⁴ These provisions may have future spillover implications for the nonprofit hospital sector.

☒ These 2010 developments suggest that there will be no respite in 2011 from close regulatory attention to executive compensation matters, at state, federal, regulatory, and legislative levels. Form 990 disclosures will continue to prompt media and legislative criticism, especially with respect to retirement benefits. Emphasis on the role and independence of the compensation committee will increase, as will scrutiny of retirement benefits payable to nonprofit executives.

6. Best Practices

Corporate governance “best practices” of relevance to nonprofit organizations continued to emerge in 2010 with unavoidable force and considerable detail. This has prompted sophisticated nonprofit hospitals organizations (and their board governance committees) to revise the scope of corporate responsibility-related policies and procedures. Of course, “best practices” are intended to serve as aspirational goals for governing boards, not actual standards of conduct. However, satisfaction of best practices generally is considered to be an effective prophylactic against fiduciary liability. Of greater interest to the nonprofit sector, though, may be the possibility that “best practices” will increasingly be applied as a template governance evaluation tool (i.e., baseline standard of conduct) by well-intentioned, but under-staffed/under-funded charity officials.

³³ See, e.g., Diane Freda, “Exempt Organizations: Changes to Compensation Safe Harbor Not Offered in Health Care Reform Markup,” 18 HLR 10/8/09.

³⁴ Peregrine and Cotter, “Dodd-Frank: The Spillover Impact on Nonprofit Healthcare,” *Health Lawyers Weekly*, July 30, Vol. III, Issue 29, www.healthlawyers.org.

In this regard, 2010 “best practices” development was noteworthy to nonprofit hospitals. Particularly valuable was the Dec. 20, 2010, release of Moody’s Investors Service Special Comment, “Governance and Management of Not-for-Profit Healthcare Organizations: A Key Driver of Ratings.”³⁵ This special comment identified five specific governance practices which Moody’s believes may contribute favorably to the hospital credit rating analysis: (a) stable and capable board and senior management team; (b) oversight and disclosure processes that serve to reduce risk and enhance questionnaire effectiveness; (c) execution of short term and long term strategic planning to optimize resource allocation; (d) a commitment to board self-assessment and benchmarking to promote ongoing governance improvement; and (e) effective board oversight of government relations.

Also instructive is the January, 2010, settlement of the New Jersey attorney general’s 16-count civil fiduciary data-based complaint against the board leadership and president of nonprofit Stevens Institute of Technology (see above).³⁶ This settlement included the adoption of a series of governance practices and procedures relating to board oversight and key (e.g., executive, audit investment, and executive compensation) committee practices, and mandated the appointment of an outside special counsel to monitor the organization’s implementation of the practices and procedures. The Attorney General’s Office described the governance changes as “best in class” for nonprofit organizations.

Other nonprofit sector governance best practices-related statements released in 2010 included (a) The Association of Governing Boards of Colleges and Universities “Board Responsibility for Institutional Governance”³⁷; (b) The American Council of Trustees and Alumni “Cost Cutting Guide”³⁸; and (c) republication through The Governance Institute of the three nonprofit health care board of directors compliance resource guidance jointly published by HHS OIG and AHHA in 2004, 2006, and 2007, respectively.³⁹ Furthermore, the ALI/ABA “Restatement of Law of Nonprofit Organizations” neared completion in 2010.

Also of interest was the December decision of Harvard University (through its core governing entity, the Harvard Corp.) to revise its board composition, structure, and practices as a modernization effort.⁴⁰ Of particular relevance to nonprofits was Harvard’s focus on restructuring governance to facilitate review of strategic challenges and opportunities (i.e., the long-term view).

Several valuable and highly relevant best practices statements emerged from for-profit-oriented organizations in 2010. Leading these was the “Principles of Corporate Governance” released by the highly influential

³⁵ See, www.moody's.com.

³⁶ Press Release, New Jersey Attorney General, “Stevens Institute to Adopt New Governance Structure,” Jan. 15, 2010, <http://www.nj.gov/oag/newsreleases/10/pr20100115b.html>.

³⁷ <http://www.agb.org/statement-board-responsibility-institutional-governance>.

³⁸ <https://www.goacta.org/publications/downloads/CuttingCostsFinal-med.pdf>.

³⁹ <http://www.governanceinstitute.com/>.

⁴⁰ http://president.harvard.edu/reports/101206_governance.pdf.

The Business Roundtable.⁴¹ Other notable publications were the “Key Agreed Principles to Strengthen Corporate Governance” from the National Association of Corporate Directors; white papers on enterprise risk management published by both NACD and by The Conference Board, and the Report of the New York Stock Exchange Commission on Corporate Governance. Given the general similarity of the governance provisions of state laws governing business corporations and nonprofit corporations, these 2010 best practices statements offered an additional resource to hospital and health system governance.

Also from the for profit sector, both new SEC disclosure rules, and portions of the Dodd/Frank Act, contained governance provisions of possible relevance to the nonprofit sector. These included provisions requiring disclosure of certain board leadership issues (Dodd/Frank) and disclosure of the qualifications/experience/attributes of each director or nominee (SEC rules).

☒ The prudent pursuit of governance best practices by nonprofit boards is welcomed by charity officials as a demonstration of good faith. In addition, the periodic evaluation of the sufficiency of existing governance practices is highly recommended. Accordingly, hospital boards and their governance committees should continue in 2011 to be attentive to the evolving formation of governance best practices for nonprofit organizations, as demonstrated by new policy statements, rating agency analyses, and prominent nonprofit sector governance reorganizations.

7. Conflicts/Independence

Nonprofit boards came under substantially increased pressure in 2010 to address and resolve issues related to conflict of interest and director independence. This pressure reflected public policy interest in protecting the integrity of the nonprofit board’s decision making process. This interest was prompted, in large part, by increasing intolerance from legislatures, charity regulators and the media/public with perceived ethical lapses by nonprofit governance.

In this regard, conflicts arising from director-as-vendor arrangements became a leading issue in 2010. The substantial extent of this practice was detailed in the IRS’s 2009 Hospital Industry Report.⁴² However, the tenor of the dialogue was sharpened by the March 14, 2010, publication of a survey of these types of relationships by the influential *Chronicle of Higher Education*.⁴³ The survey served to illustrate the extent of director-as-vendor practice in a highly unflattering perspective (even though the practice is not typically regarded as *per se* illegal under state law).

The IRS Form 990 returns filed by nonprofits in 2010 served to focus particular attention on conflicts and independence issues. Particularly relevant in this area were responses to the Part VI questions with respect to “intra-board” conflicts (e.g., conflicts *between* board members); the conflicts implications of nonfinancial re-

lationships of board members; the extent of independent director representation on the governing board; and business arrangements between the nonprofit organization and its officers, directors, and key employees.

The fiduciary duty implications associated with the “appearance of conflict” and reputational harm were highlighted by the Sept. 1, 2010, letter of the Massachusetts attorney general to the Beth Israel Deaconess Medical Center board.⁴⁴ The ultimate issue addressed by the letter was the importance of preserving board independence from management, as it relates to executive compensation, dual office holding, diligent management, oversight and conflicts of interest. In the context of its observations, the attorney general was critical of what it perceived as the failure of certain board leaders to directly confront the CEO on the controversy at hand. In addition, the Senate Finance Committee conducted a series of inquiries of leading disease focused charities with respect to the potential conflicts arising from substantial outside funding received from pharmaceutical companies and other similar third party funding sources.⁴⁵ Thirty-three organizations were asked to provide information on a variety of potential areas of board conflict, including financial relationships of board members and outside firms that would create conflicts. These inquiries served to underscore the value of examining the potential for governance conflicts to arise from nontraditional sources.

Anecdotally, there appeared in 2010 to be a subtle call from the media and some charity regulators to a return to trust law standards as they relate to the prohibition of any form of conflict or self dealing by nonprofit board members. Indeed, a few leading nonprofit hospital systems are understood to have adopted (or be actively considering the adoption of) a “no-conflicts” requirement for board membership. While such a standard would exceed the requirements of nonprofit law, a voluntary return to trust law standards suggests the concern of some nonprofit organizations with the reputational concerns attributable to board conflicts.

Many nonprofit hospitals and health systems continued in 2010 to address the proper definition of “independent director” in the absence of an all-encompassing definition appropriate for both corporate and tax exemption purposes. While the Form 990 glossary definition of “Independent Voting Member of the Governing Body” often served as a default definition, many hospitals and health systems struggled to find proper definitional balance between state corporate law, the Form 990, the IRS’s “Community Benefit Standard”; Principle No. 12 of the Panel on the Nonprofit Sector, and Sarbanes/Oxley concepts of independent director.

☒ Further clarity on proper board independence standards is not to be expected in 2011 even in the presence of continual emphasis on the importance of control of the board and of key committees by independent directors. Nevertheless, nonprofit boards are encouraged to adopt governance definitions, and practices, that support independent board oversight and (separately) effective conflict of interest practices.

⁴¹ <http://businessroundtable.org/studies-and-reports/2010-principles-of-corporate-governance/>.

⁴² IRS Nonprofit Hospital Project—Final Report <http://www.irs.gov/charities/charitable/article/0,,id=203109,00.html>.

⁴³ “Colleges’ Deep Business Links With Trustees,” *The Chronicle of Higher Education*, March 14, 2010; Fain, Bartlett and Beja, “Divided Loyalties,” *The Chronicle of Higher Education*, March 14, 2010.

⁴⁴ http://www.mass.gov/Cago/docs/nonprofit/Beth_Israel_Hospital_Review_090110.pdf.

⁴⁵ Suzanne Perry, “Senator Examines Disclosure of Board Member Ties to Medical Companies,” *The Chronicle of Philanthropy*, Sept. 6, 2010.

8. Compliance Oversight

The combination of substantially increased anti-fraud and abuse enforcement activity, high-profile regulatory settlements and key amendments to compliance plan guidelines placed renewed emphasis in 2010 on the health care board's exercise of its *Caremark* compliance plan fiduciary oversight obligations.

The importance of this oversight was underscored in an article authored by HHS Inspector General Daniel Levinson and published in the July/August 2010 edition of *Trustee Magazine*.⁴⁶ The IG's comments served to encourage the board to be more assertive in the exercise of compliance oversight.

The importance of active compliance oversight was underscored by the increased fraud and abuse/Stark/False Claims Act enforcement actions. Indeed, the DOJ claimed to recover a record \$2.5 billion in FY 2010 from health care fraud-related FCA-based cases.⁴⁷ In addition, the PPACA contained a series of significant anti-fraud and Medicare/Medicaid program integrity initiatives. The PPACA also directed CMS to develop a template corporate compliance plan for hospitals, the publication of which could conceivably prompt changes in existing industry compliance practice. Also, as noted above in 2010, HHS OIG authorized republication (by the Governance Institute) of the three hospital governing board compliance guidance, originally jointly published by the OIG and AHLA in the mid 2000s.

In March, the U.S. Sentencing Commission adopted an important amendment to the Federal Sentencing Guidelines with respect to compliance officers-to-board reporting requirements.⁴⁸ Henceforth, in order for a compliance plan to be regarded as "effective" for sentencing guideline purposes, the corporate compliance officer must have a direct and unrestricted reporting relationship to the governing board. The goal of this amendment was to position the board to have ready access to the reports of the compliance officer, without interference or conflict.

The importance placed on board oversight of corporate compliance also was demonstrated in corporate integrity agreements entered into between HHS OIG and several nonprofit health systems in 2010.⁴⁹ Each of these CIAs contained roughly equivalent terms requiring enhanced board supervision of the organization's corporate compliance program. These requirements included scheduled board meetings to review compliance matters; board resolutions stating that the board or board committee has concluded other reasonable inquiry that the compliance program is "effective"; and certifications regarding effectiveness from individual board/board committee members. Such terms were consistent with the position adopted by the New York Medicaid inspector general, who stated in 2010 a will-

⁴⁶ Daniel Levinson, "Trustee Engagement and Hospital Success" *Trustee*, July/August 2010; http://www.trustee.com/search?q=levinson&vse_submit=GO&tab=&d=.

⁴⁷ "Department of Justice Recovers \$3 Billion in False Claims Cases in Fiscal Year 2010"; <http://www.justice.gov/opa/pr/2010/November/10-civ-1335.html>.

⁴⁸ April 30, 2010—Amendments to the Sentencing Guidelines, Policy Statements, and Official Commentary. http://www.ussc.gov/Legal/Amendments/Official_Text/20100430_Amendments.pdf.

⁴⁹ See, e.g., <http://oig.hhs.gov/fraud/cias.asp>.

ingness to hold governing boards responsible for organizational compliance failures.⁵⁰ The CIA provisions also were consistent with increasing HHS OIG emphasis on exclusion from Medicare participation of fraud-accountable corporate executives (see below).

☒ In these and other respects, 2010 reflected an increasing willingness of health care regulators to hold governing boards to greater accountability with respect to compliance plan oversight. This can be expected to continue (if not increase) in 2011, especially given the anti-fraud emphasis of the PPACA and application of responsible corporate officer principles.

9. Enterprise Risk Management.

In the recession's 2010 wake, expectations increased that nonprofit hospitals and health systems would more actively assess the effectiveness of internal mechanisms designed to monitor business risk and preserve charitable assets. Principles of "enterprise risk management" became more clearly relevant to the nonprofit hospital sector. Particular focus in this regard was placed on organizational exposure to economic conditions, the potential impact of new laws and regulations, and changes to the competitive environment. The principle motivation for the increased application of "ERM" principles to health care was the general recognition of the scope, length and breadth of the recession—and the failure of all sectors of commerce (including health care) to predict and adapt to it. Enhanced ERM concentration also was perceived as consistent with the increased regulatory focus on the board's oversight obligations.

A particular manifestation of this development was 2010 federal rulemaking and legislation incorporating ERM concepts in a manner likely to have ultimate spill-over impact on nonprofit health care. For example, new SEC disclosure rules finalized in early 2010 mandated description of the board's role in the oversight of risk, e.g., how the board administers its oversight function and the effect this has on the board's leadership structure. In addition, a central theme of the Dodd/Frank legislation is the regulation (i.e., reduce or mitigate) of systemic risk in the financial sector.

In addition, a series of important white papers were published by influential public policy groups (e.g., Natural Association of Corporate Directors, The Conference Board) emphasizing adoption of ERM mechanisms as governance "best practice."⁵¹

The relevance of ERM principles to nonprofit health care was underscored by three particular 2010 developments: (a) the enactment of the PPACA and the fundamental strategic, financial, and operational issues arising therefrom; (b) the increased operational, reimbursement and legal focus on quality of care issues; and (c) congressional pressures on continuing favorable tax exemptions fundamental to the nonprofit hospital financial model. ERM principles speak to the need of the governing board to recognize and address these types of seismic organizational challenges.

⁵⁰ "New York State Medicaid Inspector General Calls for Board Involvement in Compliance," PR Newswire Association LLC, April 1, 2010.

⁵¹ See, e.g., The Conference Board, "Adapting to Regulatory Developments and Emerging Practices", www.conferenceboard.org; See, also, Peregrine, "ERM—It's BAAACK! Fiduciary Duty and Enterprise Risk Management," AHLA Connections, June 2010.

☒ The current health care business environment of slower growth, reimbursement uncertainty, increased regulation and rapid integration may lead boards to enhance their oversight of management's assessment and mitigation or risks.

10. Strict Accountability

A more ominous governance trend emerging in 2010 was the increased willingness of regulators to hold health industry officers and directors strictly accountable for certain types of alleged corporate misconduct, even in situations where the alleged misconduct was removed from the officers/directors' oversight and where they should not reasonably have been expected to have been aware of the alleged misconduct.

This "Responsible Corporate Officer" (RCO) concept of strict liability is based on several Supreme Court decisions which upheld the conviction of corporate officers for public welfare based misdemeanors without evidence that they had knowledge of, or participation in, the problematic criminal activity. Over the past several years, RCO theories have been applied by the Department of Justice to pursue allegations against pharmaceutical and medical device companies under the Federal Food, Drug, and Cosmetic Act (which contains a strict liability provision for misdemeanor misbranding and adulteration violations).

Until 2010, the nonprofit health care sector had not reasonably been exposed to RCO-type liability risks. Evidence of illegal intent remains an essential element to most key health care anti-fraud criminal statutes, making strict liability principles inapplicable. Without much fanfare, the environment shifted with the October, 2010, release by HHS OIG of internal guidance introduced to underscore its expressed intention to increase the use of its permissive authority to exclude individual corporate officers and managers from participation in federal health care programs⁵², a virtual employment "death sentence." Public comments by OIG and DOJ officials reflect a willingness to pursue exclusion of health care officers/executives "even if they did not have knowledge of the crime." Thus, this new internal guidance serves to bring RCO principles to the doorstep of nonprofit hospitals (and its key leadership).

Under pre-existing statutory authority, OIG was granted broad authority to exclude officers and managing employees of a "sanctioned entity" (e.g., one convicted of crimes relating to patient neglect or abuse or felony health care fraud). Depending upon their application, the new guidelines could subject a large section of hospital management (including but not limited to officers and directors) to Medicare/Medicaid exclusion should the organization itself be sanctioned. The specific RCO connection is that, pursuant to the guidelines, the OIG is authorized to exclude individuals based solely on the basis of their organizational position, without regard to the scope of their organizational responsi-

⁵² "Guidance for Implementing Permissive Exclusion Authority Under Section 1128(b)(15) of the Social Security Act"; available at http://oig.hhs.gov/fraud/cia/cia_list.asp.

bility or their actual knowledge of the sanctioned conduct.

The government's interest in asserting individual accountability for health care organization wrongdoing was also evidenced in 2010 by the House's adoption of the "Strengthening Medicare Anti-Fraud Measures Act of 2010."⁵³ The bill would expand HHS OIG's exclusion authority to cover (under certain circumstances) (a) executives if their employer was sanctioned [for conduct that occurred during the period of the executive's employment] after the executive had left the organization; and (b) parent companies of sanctioned entities. This "Stark Bill" was not adopted by the Senate prior to the end of the congressional year, but Ways and Means Committee leadership has expressed an interest in reintroducing the bill in 2011.

Along the same lines, it should be noted that the IRS continued in 2010 its practice of asserting "strict liability" principles with respect to officers and directors of organizations that violated employment tax withholding requirements.⁵⁴

☒ While "responsible corporate officer" and other strict liability doctrines are unlikely to be asserted broadly against officers and directors of nonprofit health care organizations, their relevance to the sector is no longer speculative. As a result, accountability theories of liability concepts should be considered by boards in 2011 when evaluating their liability risk profile. In addition, they are consistent with a general interest of the government in attributing (where appropriate) responsibility for problematic corporate conduct to appropriate individuals.

Conclusion

2010 was a year in which developments in corporate law and governance, as applied to nonprofit hospitals and health systems, continued apace. Of particular significance were the increased level of regulatory interest in governance practices of nonprofit organizations, evolving pressures on the business judgment of nonprofit board members, the impact on nonprofit governance of the transitional economy, and the adoption of the PPACA.

Collectively, these developments reflect greater interest in the application of nonprofit and charitable trust law concepts on a variety of public and private levels. It is the authors' perspective, however, that these developments should not be a basis to question the continued propriety and reasonableness of nonprofit status. Rather, counsel to such organizations should be mindful of identifying nonprofit corporate law as a principle legal issue when conducting any material legal analysis for a health care client.⁵⁵

⁵³ The text of the bill is available at: <http://go.usa.gov/xZb>.

⁵⁴ *Davis v. United States*, 5th Cir., No. 09-30392, unpublished, 11/22/10; see also "Fifth Circuit Says Five Liable for Hospital's \$11 Million in Unpaid Employment Taxes," *BNA's Health Care Daily Report*, 11/19/10.

⁵⁵ The authors wish to acknowledge the contributions of Ralph DeJong and John Callahan of McDermott, Will and Emery, and Elizabeth M. Mills of Proskauer Rose, to the preparation of this article.