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## Key Nonprofit Corporate Law Developments for Health Care Providers in 2011



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The year 2011 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 more than 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 business judgment by boards; (d) the evolution of system structures and business combinations; (e) the governance implications of an economy in transition; and, (f) calls for greater individual accountability across the commercial sector.

Based on these trends, our “top ten” list of major nonprofit corporate law developments for health care providers in 2011 is as follows:

### 1. Health System Structures

The increasing reliance on the health system corporate model to control and operate nonprofit hospitals

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was affected by several significant corporate and related legal developments in 2011.

Particularly notable was the May 26 federal district court decision in the long-running litigation involving Lifespan Corp. and New England Medical Center (now known as Tufts Medical Center in Boston, Mass.).<sup>1</sup> The court's crucial holding was that by certain of its actions or nonactions, Lifespan breached its fiduciary duties owed to NEMC, for which damages were owed. Despite its unique facts, the *Lifespan* decision may have important implications for many parent-affiliate relationships in the nonprofit sector.

The case involved a highly complex fact pattern arising from a parent (Lifespan)/subsidiary (NEMC) affiliation that had soured. The litigation arose when Lifespan initiated a breach of contract action against NEMC for the latter's failure to pay the final two installments due Lifespan under an agreement previously entered into by the parties to unwind their relationship. NEMC filed a counterclaim for breach of fiduciary duty, unjust enrichment, and unfair business practices, and sought to recover its losses allegedly caused by Lifespan's misconduct as the parent entity. The Massachusetts attorney general intervened in the case on behalf of NEMC.

Prior to trial, the court ruled in a motion for summary judgment in favor of Lifespan on the breach of contract claims, and also ruled that Lifespan had a fiduciary relationship with NEMC. The court concluded that this relationship existed by virtue of Lifespan's control over NEMC, and the “faith, confidence and trust” that NEMC placed in Lifespan's judgment and advice.<sup>2</sup>

The issue of whether Lifespan actually breached that fiduciary relationship was addressed in a subsequent three week bench trial. The court (after rejecting certain of the claims made by NEMC and the AG) found that, with respect to certain aspects of its relationship and authority, Lifespan had violated its fiduciary duties of care and loyalty toward NEMC and had committed gross negligence, willful misconduct, and made misrepresentations to NEMC. The court ultimately awarded NEMC a net judgment of \$9.2 million.

The case is significant for health system development for three particular reasons. *First*, it is the second recent decision concluding that parent companies indeed owe their controlled, but separately incorporated, affiliated

<sup>1</sup> *Lifespan Corp. v. New Eng. Med. Ctr. Inc.*, 2011 WL 2134286 (D.R.I. 2011) (20 HLR 830, 6/2/11).

<sup>2</sup> The decision articulated a series of specific elements of the fiduciary relationship.

hospitals basic fiduciary duties (to wit, the duties of care and loyalty);<sup>3</sup> *Second*, it identifies parent company conduct that may in certain circumstances constitute a breach of such fiduciary duties for which monetary damages may be assessed; and *Third*, it reflects the willingness of the state attorney general to intervene in a cross-border dispute involving members of an interstate health care system in order to protect the interests of the “home state” nonprofit hospital and its charitable assets.

Also of significance was the June 8 decision of the U.S. Court of Appeals for the Seventh Circuit in *Girl Scouts of Manitou Council Inc. v. Girl Scouts of the United States of America Inc.*<sup>4</sup> This case involved, in essence, a local GSUSA chapter successfully applying state franchise/fair dealership laws to enjoin GSUSA from terminating the chapter in a system reorganization.

The Seventh Circuit held that networks of affiliated nonprofits may be governed by state franchise laws, a body of law that the parties likely never considered as applicable to their relationship at the time they created their alliance. Franchise laws tend to be distributor (in this case local chapter) biased. Franchise laws vary, sometimes significantly, from state to state, so a large health system parent could be affected by this decision in varying ways from state to state (particularly parent decisions to disaffiliate subsidiaries), creating meaningful uncertainty and a lack of consistency throughout the organization.

While an obscure decision, the *Girl Scouts* case already is creating substantial concern among large national disease prevention and social service agencies that operate on a national headquarters association/local chapter’s relationship. It is conceivable that an aggrieved party in an intra-health system structural dispute may seek to apply franchise laws in support of its position.

A more positive 2011 development was the Oct. 18 proposal by the Centers for Medicare & Medicaid Services (CMS) to revise a previous interpretation of certain hospital “conditions of participation” (COP) that will, when made final, facilitate the use of a unified governing board for all hospitals in a health system.<sup>5</sup>

Many multi-hospital health systems have considered (or already implemented) use of a “unified” governing board; *i.e.*, when the same individuals serve as governing board members for each of the “parent” entity and every Medicare-certified hospital in the health system, to streamline and better coordinate their governance structures. (In this model, there is no separate “fiduciary board” at the hospital level). CMS has, until recently, taken the position on survey that these governing body COPs require *each* hospital in a health system with its own CMS certification number to have a completely separate governing body (as well as a separate medical staff); *i.e.*, a board that acts for a hospital in a

distinct, separate manner. This interpretation effectively prohibited the use of a unified governing body between the health system parent and its hospitals.

The proposed rule reflects CMS’s new understanding that multiple hospitals can in fact be effectively governed by a single unified governing body, and seeks “to revise and clarify the governing body requirement to reflect current hospital organizational structure whereby multi-hospital systems have integrated their governing body functions to oversee care in a more efficient and effective manner.”<sup>6</sup> CMS was able to resolve, with the assistance of stakeholder comments, its prior concern that the use of unified boards would “mask” material quality of care issues.

## 2. Fiduciary Duties

A series of significant 2011 developments had implications for the application of fiduciary duties by the officers and directors of nonprofit hospitals and health systems. These developments suggest that while case law continues to support generous standards for director conduct, it will not offer “bullet proof” protection in matters of significant controversy.

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A notable example was the Sept. 21 decision of the U.S. Court of Appeals for the Third Circuit in *In re Lemington House for the Aged*.<sup>7</sup> The case arose from the bankruptcy of a historic Pittsburgh-area retirement facility. The Third Circuit vacated (and remanded for trial) the district court’s prior decision to grant summary judgment in favor of the defendants (the home’s officers and directors) on breach of fiduciary duty and deepening insolvency claims asserted by the Committee of Unsecured Creditors. The district court had determined that summary judgment was appropriate because the business judgment rule and the doctrine of *in pari delicto* barred recovery on the fiduciary breach claims, and the committee had not presented facts demonstrating the fraud necessary to support the deepening insolvency claim.

The Third Circuit’s independent review of the record identified genuine disputes of material facts on all claims (painting a highly unflattering portrait of board and officer oversight and action). Particularly notable was the Third Circuit’s interpretation of Pennsylvania law. This included a determination that the fiduciary duties of a nonprofit director are owed not only to the corporation but also to the creditors of an insolvent entity. The Third Circuit also identified facts supporting a rational conclusion that the home’s officers failed to ex-

<sup>3</sup> *Health Alliance of Greater Cincinnati v. Christ Hosp.*, 2008 Ohio 4981 (Ohio Ct. App., Hamilton County, Sept. 30, 2008) (17 HLR 1305, 10/2/08).

<sup>4</sup> *Girl Scouts of Manitou Council v. Girl Scouts of the United States Inc.*, 646 F.3d 983 (7th Cir. 2011).

<sup>5</sup> Medicare and Medicaid Programs; Reform of Hospital and Critical Access Hospital Conditions of Participation, 76 Fed. Reg. 65891 (Oct. 24, 2011), available at <http://www.gpo.gov/fdsys/pkg/FR-2011-10-24/pdf/2011-27175.pdf>.

<sup>6</sup> *Id.*

<sup>7</sup> *Official Comm. of Unsecured Creditors ex rel. Estate of Lemington Home for the Aged v. Baldwin (In re Lemington Home for the Aged)*, 659 F.3d 282 (3d Cir. 2011) (20 HLR 1456, 9/29/11).

ercise reasonable diligence, were not disinterested, and had favored a related entity over the home—concluding that under those circumstances the application of the business judgment rule could not be decided on a summary judgment motion. The court also held that there was evidence such that a fact-finder could conclude that the home's directors did not have a reasonable basis to believe that the officers in question were reliable and competent. In a number of jurisdictions, prerequisites to obtaining the protection of the business judgment rule include “reasonable inquiry” and that the directors believe that the officers and employees upon whom they are relying are “reliable and competent.”

A somewhat different approach was taken earlier in the year by the Tennessee Supreme Court in *Sanford v. Waugh & Co.* holding as a matter of law that creditors have no right to assert breach of fiduciary duty claims against the officers and directors of a corporation that is insolvent or in the “zone of insolvency.”<sup>8</sup> The Tennessee Supreme Court's decision is consistent with a series of prominent Delaware decisions which provide directors with greater protections and flexibility to deal with organizational/functional distress.

Another notable development was the Dec. 13 decision by the U.S. District Court for the Central District of California in *Federal Deposit Insurance Corp. v. Perry*, concluding that the protections of the business judgment rule do not extend to officers of California corporations (but only to directors).<sup>9</sup> The case arose from the FDIC's \$600 billion claim against a former residential home lender executive for negligence in the sale of over \$10 billion in allegedly flawed loans on the secondary market. While the ruling is contrary to decisions in other jurisdictions (e.g., Delaware),<sup>10</sup> the district court found no California authority or legislative intent to include officers within the scope of the common law business judgment rule. Notably, California nonprofit corporation law (like the general corporation law) has codified the business judgment rule (Corp. Code 5231) and the statute only references directors. Applying this decision, loss of business judgment rule protection could expose officers of California nonprofit corporations in a number of fiduciary breach situations, including but not limited to actions brought by the attorney general in *parens patriae* on behalf of charitable beneficiaries.

It is noteworthy that these fiduciary duty developments all arise from financial distress/bankruptcy settings, which frequently do not involve fact patterns flattering to officers and directors. This underscores the traditional perspective that fiduciary duty breach exposure is higher when the corporation is the subject of financial or compliance controversy.

### 3. Compliance Oversight

The health care board's compliance plan oversight obligations—a subset of the duty of care—received significant attention from the courts and regulators in 2011.

The importance attributed to the exercise of this duty was evidenced by the reissuance of the three director compliance oversight monographs, originally published

in the mid-2000s by HHS OIG and AHLA.<sup>11</sup> The reissuance was made in a consolidated format, combining the three monographs in a single document with a new introduction. The monographs address issues associated with the director's basic *Caremark*<sup>12</sup> oversight obligations, its responsibility to coordinate the roles of the general counsel and the compliance officer, and its unique compliance oversight responsibilities with respect to quality of care.

Similar emphasis was placed on board support of the role and function of the compliance officer. In a series of speeches, publications and corporate integrity agreements,<sup>13</sup> HHS OIG has advocated for the positions to be separated and held by different persons, and for the compliance officer to have a barrier-free vertical reporting relationship (i.e., not reporting to the general counsel, who OIG perceives as having a conflict of interest). This is in addition to the November 2010 amendments to the Federal Sentencing Guidelines that require the establishment of a direct, unrestricted reporting relationship from the compliance officer to the board.<sup>14</sup>

Another *Caremark* obligation receiving substantial 2011 attention was the board's oversight of the compliance implications of quality of care. HHS OIG increasingly has emphasized the need for a more comprehensive and pro-active board approach to quality oversight and the related compliance implications. This is in large part based on new government emphasis on sanctioning health care providers (both individuals and institutions) for providing substandard care to beneficiaries of federal health care programs.<sup>15</sup> These sanctions can range from civil money penalties, to exclusion, and even to incarceration in extreme circumstances.

Also in 2011, responsible corporate officer doctrine (RCOD)-based enforcement theories became credible compliance/fiduciary liability risks for the officers, directors, and key employees of hospitals and health systems.<sup>16</sup> RCOD enforcement and OIG's new permissive exclusion authority<sup>17</sup> reflect the focus of federal health care enforcement not only on corporate actions, but also on holding individuals accountable for corporate noncompliance; either through direct proof of their knowledge of noncompliant practices or through strict

<sup>11</sup> Health Lawyers Public Information Series, *The Health Care Director's Compliance Duties: A Continued Focus of Attention and Enforcement*, <http://www.healthlawyers.org/hlresources/PI/Documents/Health%20Care%20Director's%20Compliance.pdf>.

<sup>12</sup> *In re Caremark Int'l. Inc. Derivative Litigation*, 698 A.2d 959 (Del. Ch. 1996).

<sup>13</sup> For a summary, see Peregrine and Buchman, “Managing the General Counsel/Compliance Officer Relationship,” *AHLA Connections*, October 2011, available at [http://www.mwe.com/info/pubs/Analysis\\_Oct20111.pdf](http://www.mwe.com/info/pubs/Analysis_Oct20111.pdf).

<sup>14</sup> [http://www.ussc.gov/Legal/Amendments/Official\\_Text/20110428\\_Amendments.pdf](http://www.ussc.gov/Legal/Amendments/Official_Text/20110428_Amendments.pdf).

<sup>15</sup> See, e.g., <http://oig.hhs.gov/compliance/corporate-integrity-agreements/quality-of-care.asp>.

<sup>16</sup> For a summary of recent developments, see Peregrine and Buchman, “A Responsible Corporate Officer Defense Plan,” *AHLA Connections*, May 2011, <http://www.healthlawyers.org/News/Connections/CURRENTISSUE/Pages/default.aspx>.

<sup>17</sup> Guidance for Implementing Permissive Exclusion Authority Under Section 1128(b)(15) of the Social Security Act, [http://oig.hhs.gov/fraud/exclusions/files/permissive\\_excl\\_under\\_1128b15\\_10192010.pdf](http://oig.hhs.gov/fraud/exclusions/files/permissive_excl_under_1128b15_10192010.pdf).

<sup>8</sup> *Sanford v. Waugh & Co.*, 328 S.W.3d 836 (Tenn. 2010).

<sup>9</sup> *FDIC v. Perry*, 2011 U.S. Dist. LEXIS 143222 (C.D. Cal. Dec. 13, 2011).

<sup>10</sup> See, e.g., *Gantler v. Stephens*, 965 A.2d 695 (Del. 2009).

liability (i.e., by virtue of their position in the corporate hierarchy).

#### 4. Conflict of Interest

During 2011 nonprofit regulators, charity “watchdogs” and the media continued their historical interest in scrutinizing alleged conflicts of interest involving officers and directors of hospitals and health systems, and other large charitable organizations.

Most prominent was that portion of the *Lifespan* decision and related damage award attributable to a unique conflict of interest involving Lifespan’s chief financial officer.<sup>18</sup> As noted above in Section 1, one of the district court’s significant rulings was that Lifespan had breached its duty of loyalty owed to NEMC by causing NEMC to enter into a complex financial transaction without disclosing the CFO’s conflict in pursuing that transaction.

This conflict of interest arose from the CFO’s unusual and undisclosed personal and financial relationship with the investment banker who recommended that NEMC pursue the complex transaction. The court concluded that this relationship provided the banker with “preferential access” in connection with the transaction and influenced the CFO’s decision to pursue the transaction over NEMC objections. Notable was the court’s conclusion that the CFO was particularly motivated by a desire to “please” his banker/friend, likely in hope of joining a wine partnership in which the banker held an interest. The court determined that this conflict of interest was the proximate cause of the damage NEMC suffered in the financial transaction, and awarded over \$8 million in damages attributable to this particular breach.

The attentiveness with which hospital and health system boards address conflict of interest issues also was influenced by two highly publicized developments arising outside of the nonprofit sector.

The first involved the ethics investigation of the former general counsel of the Securities and Exchange Commission,<sup>19</sup> David Becker. Over a period of time commencing with his joining the SEC, Becker disclosed to the SEC chairwoman as well as the SEC chief ethics officer that he had inherited Madoff-related proceeds from his mother’s estate. The chief ethics officer specifically approved Becker’s participation in activities related to establishing a compensation formula for Madoff victims.

After investigation, the inspector general of the SEC referred the matter to the Justice Department to determine whether federal conflict of interest laws for government employees had been violated. While federal conflict of interest law requires that government employees be disqualified from participating in a matter if it would have a direct and predictable effect on the employee’s own financial interest, the inspector general wrote that Becker nevertheless “participated personally and substantially in particular matters in which he had a personal financial interest.” The inspector general’s report was, moreover, critical of the agency for failing to recognize the conflict and not taking action to sug-

gest that Becker recuse himself from the Madoff liquidation. Ultimately, the Department of Justice declined to pursue the matter.<sup>20</sup>

On a practical perspective, the Becker affair offered lessons on both the quality and quantity of conflict disclosures, and the balance between conflicts management and recusal. On a policy level, it offered guidance on possible increasing expectations and standards with respect to conflict disclosure and review.

The second development was the March decision of the U.S. Court of Appeals for the Seventh Circuit, in *CDX Liquidating Trust v. Venrock Associates*.<sup>21</sup> In this case, the Seventh Circuit made the highly important clarification that, while the disclosure of a director’s conflict of interest may “insulate” [a transaction or] agreement from attack, it does not automatically protect a director from a claim for breach of fiduciary duty. The ruling arose from a situation in which a principal of a venture capital firm that had funded the company subsequently became a board member of the company. As a board member, the venture capitalist helped to negotiate the company’s relationships with other lenders. These negotiations led to transactions that ultimately proved disastrous for the company but that benefitted the venture capital firm. The common shareholders brought a breach of duty of loyalty claim against the principal and several other board members. The district court ruled that the principal’s original disclosure to the company of his conflict excused any subsequent breach of duty that may have arisen in the context of the fiduciary negotiations. The Seventh Circuit disagreed, drawing the important distinction between having a conflict of interest (which in and of itself is not actionable) and actually committing a disloyal act (which is, of course, actionable). Thus, an act of disloyalty is not excused merely through a disclosure of the related conflict of interest.

#### 5. State Review of Nonprofit Transactions

State attorneys general and other charity officials continued in 2011 to exercise their statutory and common law jurisdiction to review and approve “change of control” and similar transactions involving nonprofit hospitals and health systems. This follows a historical trend of state review highlighted by the highly publicized 2010 state reviews involving the transfer of Detroit Medical Center and Caritas Christi Health System, respectively.

A highly prominent action was the Dec. 30 decision of Kentucky Gov. Steve Beshear to reject the proposed three-way hospital merger involving the University of Louisville Hospital, Jewish Hospital & St. Mary’s HealthCare, and Saint Joseph Health System. In a brief statement, the governor concluded that the proposed merger was “not in the best interests” of the state; the risks to the transaction outweighed its potential benefits and that it would cause the state to lose control of an important public asset (the University of Louisville

<sup>18</sup> *Lifespan Corp. v. New Eng. Med. Ctr. Inc.*, 2011 WL 2134286 (D.R.I. 2011).

<sup>19</sup> See, e.g., Gretchen Morgenstern and Louise Story, “Officials Eye Role of Lawyer in Madoff Case.” *The New York Times*, Sept. 10, 2011.

<sup>20</sup> See, Louise Story, “U.S. Won’t Investigate Former SEC Lawyer Over His Madoff Ties,” *The New York Times*, Nov. 8, 2011.

<sup>21</sup> *CDX Liquidating Trust v. Venrock Associates*, 640 F.3d 209 (7th Cir. 2011).

Hospital).<sup>22</sup> Reportedly, the FTC previously had declined to review the proposed transaction on antitrust grounds.

The governor's decision was based in large part on the Dec. 29 report of Kentucky Attorney General Jack Conway, which recommended against the transaction on the grounds of "unprecedented and complex legal and policy issues."<sup>23</sup> unresolved by the parties. Among these were constitutional issues arising from the potential influence of a Catholic sponsored entity on a state asset (the university hospital), protection of charitable assets, loss of control of a state asset, and legal and financial complexities associated with the unwind of the existing affiliation agreement between the university hospital and the state.

In another example, in October the California attorney general denied consent to the sale of Victor Valley Community Hospital to a nonprofit affiliate of a for-profit hospital company.<sup>24</sup> The denial letter declined to articulate any specific reasons other than that the proposed sale was not in the public interest and likely to create a significant effect on the availability or accessibility of health care services to the community. The hospital, which had filed for Chapter 11 bankruptcy protection in 2010, previously had accepted a \$35 million offer from the nonprofit affiliate.

The Colorado attorney general was actively involved during 2011 in the proposed sale of nonprofit Colorado Health Foundation's interest in the HCA-HealthONE health system. HealthONE was a joint venture between HCA and the foundation, formed in 1995 by the consolidation of several Denver area health care facilities owned by the entities. The foundation owned a 40 percent interest in HealthONE stock and a 50 percent voting interest, and had agreed to sell its remaining interests in the joint venture to HCA for consideration in excess of \$135 million.

Following a series of public hearings and substantial public attention, the attorney general ultimately approved the sale as in the public interest and the sale price as a fair market price. In so doing, the attorney general acted in his common law authority and acted pursuant to the state's Hospital Transfer Act, which he determined did not apply.<sup>25</sup> That decision now is being challenged by opponents to the transaction, who argue that the act should apply and that the transaction is in violation of its terms.

## 6. Executive Compensation

Executive compensation for nonprofit hospital, health system, and health insurer executives is perennially a "front-burner" legal concern. This was particularly the case in 2011, during which a struggling economy served to increase scrutiny on high levels of compensation and benefits of charity executives. As in prior years, executive compensation paid by such companies has been a primary area of focus at both the

state (e.g., attorney general) and Internal Revenue Service levels.

Massachusetts Attorney General Martha Coakley's office provided much of the attention on this subject. For example, in early July the attorney general reported the conclusion of its inquiry into the compensation of the former chief executive officer of Blue Cross and Blue Shield of Massachusetts (BCBS-M).<sup>26</sup> The inquiry had been prompted by state filings by BCBS-M that indicated that its former CEO received a severance pay in excess of \$4.26 million payable over a two-year period. Special AG focus was placed on the terms of the severance obligation, the board's involvement in the approval of the obligation, the process used by the board to monitor the former CEO's performance, and the circumstances of his termination. Particular AG criticism focused on the general concept of severance pay arrangements, the overall effectiveness of the board's CEO performance evaluation process, and the appointment of board members with appropriate subject matter expertise. (Note that the organization ultimately refunded \$4.2 million to customers, an amount equal to the severance payments kept by the former CEO). All of these observations may prove helpful to other nonprofit health sector boards as they evaluate their obligations to monitor CEO performance and the extent to which they authorize executive severance arrangements.

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In late August, New York Governor Andrew Cuomo created a new task force to investigate executive compensation at nonprofit organizations that receive taxpayer subsidies from the state (including hospitals that receive Medicaid funds).<sup>27</sup> The task force was to be chaired by the superintendent of the New York Department of Financial Services, and was formed in response to an unflattering article in *The New York Times* that highlighted million dollar salaries paid as compensation to two brothers who served as senior executives of an agency they originally formed to treat the developmentally disabled.<sup>28</sup> The questionnaire that was originally sent to hospitals was highly detailed, including multiple questions, seeking specific information about compensation (undefined for purposes of the questionnaire) for their executives, administrators and board members. The initial questions went beyond those asked of tax-exempt organizations in the compensation sections of the Form 990, requested information with respect to executives earning \$100,000 or more annually, and included a series of questions of board members relating to the justification for individual compensation, and whether the organization maintains "claw back" proce-

<sup>22</sup> See, Jack Brammer, "Governor Rejects Merger of University of Louisville Hospital with St. Joseph," *Louisville Courier*, Dec. 31, 2011.

<sup>23</sup> <http://migration.kentucky.gov/NR/rdonlyres/253052EC-A3E5-45A6-96C4-E5F474720F60/0/mergereport.pdf>.

<sup>24</sup> [http://ag.ca.gov/charities/pdf/vvch\\_decision\\_2011.pdf](http://ag.ca.gov/charities/pdf/vvch_decision_2011.pdf).

<sup>25</sup> [http://www.coloradoattorneygeneral.gov/press/news/2011/10/13/attorney\\_general\\_approves\\_colorado\\_health\\_foundation%E2%80%99s\\_sale\\_hospital\\_assets\\_hc](http://www.coloradoattorneygeneral.gov/press/news/2011/10/13/attorney_general_approves_colorado_health_foundation%E2%80%99s_sale_hospital_assets_hc).

<sup>26</sup> <http://www.mass.gov/ago/docs/nonprofit/bcbs-report-final-7-11.pdf>.

<sup>27</sup> <http://www.governor.ny.gov/press/08032011TaxpayerSupportedNOT-For-Profits>.

<sup>28</sup> Ross Buettner, "Reaping Millions from Nonprofit Care for Disabled," *The New York Times*, Aug. 2, 2011.

dures for both executive and board compensation. It is expected that the results of this task force review will conclude with a report and, perhaps, proposals for additional regulation.

New Hampshire's attorney general similarly initiated, in March, a review of compensation paid to the executives of the state's 24 nonprofit hospitals.<sup>29</sup> The seeds of this review were planted in 2010, when the attorney general expressed concern with the compensation payable to the senior executives of several of the state's largest hospitals. In somewhat unusual fashion, the actual review is being conducted by an outside consulting company, which prepared a compensation survey that was sent to each of the 24 hospitals. The final report is expected to be completed in February, 2012.

Another Massachusetts-based 2011 compensation initiative has been Coakley's efforts to enact legislation that would regulate the compensation payable to board members of Massachusetts public charities, including those operating as hospitals, health systems or health insurers.<sup>30</sup> As currently proposed, the legislation would serve to prohibit charities from compensating board members without the approval of the attorney general. Such approval would be issued only on satisfaction of a "clear and convincing" standard (based on the charity's need to use compensation to attract qualified director candidates). The attorney general's position with respect to director compensation was addressed specifically in her April 14 final report regarding director compensation practices at Massachusetts nonprofit health insurance companies.<sup>31</sup> In that report, the attorney general rejected all of the varied justifications that the responding charities submitted for their decisions to compensate directors. (These justifications were similar to those identified by charitable organizations in other states as supporting their director compensation programs.) For that reason, it is likely that few Massachusetts charities would be able to satisfy the attorney general's "clear and convincing" standard should the legislation be enacted.

While the IRS did not announce significant executive compensation related initiatives in 2011, it remains a leading issue on examination with respect to tax-exempt organizations. The Service has generally refrained from issuing guidance under the intermediate sanctions rules of Internal Revenue Code Section 4958 to govern executive compensation practices of tax-exempts because those practices typically require evaluation on a facts-and-circumstances basis.<sup>32</sup> A related issue receiving substantial IRS attention is the proper accounting for fringe benefits within the context of executive compensation.<sup>33</sup>

## 7. Scandals/Investigations

Several significant investigations of nonprofit officer and director conduct occurred in 2011, involving allega-

tions of self interest, misuse of assets, violation of applicable law and absence of board oversight. Collectively, they served to tarnish the image of nonprofit organizations and to make additional arguments for close regulatory monitoring of the sector—including hospitals and health systems.

Perhaps the most prominent of these scandals involved allegations of misapplication of charitable funds involving the well-known Fiesta Bowl, which encompasses four separate nonprofit entities all recognized as income tax exempt under I.R.C. § 501(c)(3).<sup>34</sup> The genesis of the scandal was a published media report suggesting that Fiesta Bowl officials encouraged employees to make political contributions from their own funds, subject to Fiesta Bowl reimbursement, to circumvent federal campaign laws that would otherwise restrict the bowl's ability to direct contributions to specific candidates. The media report contained additional allegations with respect to expenditures for entertainment, lobbying, game tickets and trips provided to legislators which may have been excessive for a tax-exempt organization. The Fiesta Bowl board subsequently conducted an internal investigation, led by a former state attorney general, which uncovered "no credible evidence" of wrongdoing (while other governmental investigations continued). Subsequent to the completion of the internal investigation, the board was made aware of allegations that the initial investigation was compromised by the involvement of an investigator/counsel (not the former attorney general) who himself was allegedly implicated in the scandal and whose participation may have prejudiced the original investigation. A special board committee was formed to re-investigate the allegations, through the use of separate outside counsel.

The conclusions of this second investigation confirmed in large part many of the initial media reports: reimbursement through "sham bonuses" of employees for making targeted political campaign contributions, excessive expense account payments for the chief executive officer (e.g., the \$30,000 birthday party), business entertainment expenses incurred at strip clubs, etc. Upon receipt of the investigative report, the Fiesta Bowl implemented a series of public actions, including termination of the chief executive officer, and replacement of the internal general counsel. Several governmental investigations with respect to individual conduct associated with the scandal reportedly continue, although the politicians who received the inappropriate campaign contributions will not be prosecuted.<sup>35</sup>

Another prominent scandal involved the Milton S. Hershey School and other charitable enterprises associated with the Hershey Trust.<sup>36</sup> According to media reports, the Pennsylvania attorney general is conducting a noncriminal investigation relating to possible waste of assets/excessive expenditures authorized by the highly prominent organization. The controversy was brought to the public's attention by a petition filed in Orphan's Court in February by a former Hershey Co. board member, seeking damages on behalf of the school from

<sup>29</sup> See, e.g., <http://www.beckershospitalreview.com/compensation-issues/new-hampshire-ag-starts-review-of-non-profit-hospital-ceo-pay.html>.

<sup>30</sup> <http://www.mass.gov/ago/news-and-updates/press-releases/2011/ag-testifies-in-support-of-leg-to-restrict-dir-pay.html>.

<sup>31</sup> <http://www.mass.gov/ago/docs/nonprofit/director-compensation-report-4-14-11.pdf>.

<sup>32</sup> *EO Tax Today*, Tax Analysts Inc., May 5, 2011.

<sup>33</sup> IRS Employment Tax National Research Project [http://www.irs.gov/irm/part4/irm\\_04-022-010.html](http://www.irs.gov/irm/part4/irm_04-022-010.html).

<sup>34</sup> [http://www.fiestabowl.org/public/downloads/Press\\_Release\\_3-29-2011.pdf](http://www.fiestabowl.org/public/downloads/Press_Release_3-29-2011.pdf).

<sup>35</sup> Craig Harris, "No Prosecution for Ariz. Fiesta Bowl Ticket Probe," *The Arizona Republic*, Dec. 22, 2011.

<sup>36</sup> See, e.g., Bob Fernandez, "Hershey Probe Pits Corbett v. Ally," *The Philadelphia Inquirer*, Dec. 19, 2010.

school trustees, whom he claimed wasted more than \$20 million on the purchase of a golf course (allegedly partially owned by a then-trustee) and related expenditures made on behalf of trustees. The petition claimed, among other allegations, that the purchase price for the golf course was significantly in excess of appraised value. Subsequent, separate allegations reported in the media that the head of the school, a former state attorney general, was paid over \$500,000 in Hershey-related director funds in 2009; cited possible conflicts of interest involving the office of the state attorney general;<sup>37</sup> and alleged improper sponsorship of election and political campaign activity. The former board member subsequently withdrew his complaint after consultation with the attorney general, indicating confidence in the ability of the state to pursue its own investigation. Media reports in October indicated that the state has completed the fact-finding portion of its investigation. Also in October, the general counsel of the Hershey Trust was replaced by a former aide to recent Pennsylvania Gov. Edward Rendell, who as general counsel is expected to lead the negotiations between the trust, the school and the attorney general.

Investigations such as those involving the Fiesta Bowl and Hershey Trust typically have significant spillover effects on the operation of nonprofit hospitals and health systems to the extent that they focus on conduct (e.g., conflicts of interest, self-dealing, excessive and wasteful expenditures, questionable political campaign activity) that can occur at any type of nonprofit entity, and tend to undermine public confidence in the oversight capabilities of nonprofit boards.

## 8. IRS Oversight of Governance

The IRS historically has been very active in terms of its supervision of the governance of tax-exempt organizations, with significant focus in recent years on the development of Form 990 “FAQs,” audit/examination questions, “best practices,” and other guidance focused specifically on matters of corporate governance. Given that, 2011 was a relatively quiet year in terms of publicly disclosed information, enforcement action, or other guidance focused on tax-exempt organization governance, with a few notable exceptions.

On June 27, the IRS published an updated version of its FAQs on Part VI of the Form 990 (Governance, Management and Disclosure).<sup>38</sup> The release included 12 separate questions and answers relating to some of the more common issues confronted by tax-exempt organizations in completing the important governance-related questions of the 990. In this update, new information was provided with respect to matters within the scope of a committee with board-delegated power; which policies and procedures described in Part VI are required by the Internal Revenue Code; the absence of a specific requirement that the governing board review the final Form 990 prior to filing; and the due diligence required in ascertaining director independence and intra-board relationships.

Another notable development was the March 15, 2011, release of proposed Treasury regulations that would expand upon the types of information which the IRS may share with state charity officials, to include “exemption related” information; i.e., information that

relates to proposed revocation and denial of tax-exempt status, even before an administrative appeal has been made and a final decision issued regarding revocation or denial of exempt status.<sup>39</sup> Since 1969, the IRS has been required under I.R.C. § 6104(c) to notify relevant state charity officials when it revoked the tax-exempt status of an organization under the state’s jurisdiction. This notification requirement was significantly enhanced by the Pension Protection Act of 2006, to include additional information, including a notice of proposed revocation or denial of exemption, and a notice of proposed deficiency under I.R.C. Chapters 41 or 42 (which includes Section 4958, the intermediate sanctions provisions). These proposed new regulations, which implement the PPA provisions, provide for disclosure of this information upon a state’s request. They also identify circumstances in which the IRS can make the disclosure on its own request. If made final, these proposed regulations may serve to increase state law enforcement risk arising from tax exemption-based compliance issues.

Also relevant was the Oct. 6 inquiry from the House Ways and Means Committee on Oversight, chaired by Rep. Charles Boustany Jr. (R-La.), questioning what it perceived was IRS delay in efforts to increase tax law compliance by tax-exempt organizations, including, but not limited to, hospitals and health systems.<sup>40</sup> In a lengthy letter to IRS Commissioner Douglas Shulman, Rep. Boustany requested information on a number of enforcement related topics, including (a) the extent of audit and examination activity; (b) how the IRS is using information from the Form 990 (especially with respect to governance, financial and tax reporting and foreign activities) to improve current enforcement efforts and future compliance; (c) audit activity involving unrelated business income; and (d) the status of tax-exempt enforcement initiatives, including the extent to which penalty excise tax penalties under the intermediate sanctions rules have been assessed against individuals, and whether the organizations with which those individuals were affiliated have lost their tax-exempt status.

Particular focus of Rep. Boustany’s inquiry is on (a) the extent to which the IRS plans to comply with the new I.R.C. § 501(r) requirement that it review, at least once every three years, the community benefit activities of tax-exempt hospitals; and (b) the extent to which the IRS plans to satisfy the PPACA requirement that it submit an annual report to Congress regarding the level of charity care provided by all hospitals, be they taxable, tax exempt, or public in organizational status.

The interest of Rep. Boustany’s subcommittee arose in part against the backdrop of aggressive efforts of states such as Illinois to revoke state property tax exemptions of hospitals and health systems on the basis of their inability to satisfy what state regulators perceive as applicable standards for such exempt status.

## 9. Nonprofit ACO Governance

Another major 2011 development was the evolution of guidelines on the corporate structure and gover-

<sup>39</sup> Department of the Treasury, Internal Revenue Service, 26 CFR Part 301, “Disclosure of Information to State Officials Regarding Tax Exempt Organizations.”

<sup>40</sup> Stephanie Strom, “Congress Questions the IRS About Delays in its Oversight of Nonprofit Hospitals,” *The New York Times*, Oct. 31, 2011.

<sup>37</sup> *Id.*

<sup>38</sup> <http://www.irs.gov/charities/article/0,,id=211125,00.html>.

nance of accountable care organizations (ACOs) formed as nonprofit entities. As most health lawyers are aware, one of the most significant, and controversial, regulatory developments of the year was the promulgation by CMS of rules under the Patient Protection and Affordable Care Act to implement the proposed Medicare Shared Savings Program through the formation of ACOs. The final rules, published on Oct. 20, represent a substantial improvement in terms of clarity and flexibility from the March 31 proposed rule, including with respect to provisions addressing legal structure and governance.<sup>41</sup>

The final rules confirm that an ACO may be organized as any type of legal entity (including a nonprofit corporation) that is in good standing and qualified to conduct business in the state of its incorporation, as long as the entity is capable of (a) receiving and distributing shared savings; (b) repaying shared losses; (c) establishing, reporting and ensuring ACO participant and ACO provider/supplier compliance with program requirements; and performing other functions expected of an ACO under PPACA. Significantly, existing integrated entities, like a nonprofit hospital corporation that currently employs physicians, may not be required to form a separate legal entity to serve as an ACO as long as it meets the other ACO requirements under PPACA.

Given that, the governance may be created as a board of directors, a board of managers, or any other form of governing body authorized under applicable state law. The key is that the entity's governing documents provide the board with the authority to carry out the functions of an ACO as identified in the Rules (e.g., responsibility for the administrative, fiduciary and clinical operations of the ACO).

Generally speaking, the ACO rules project a theme of shared governance and proportionate control amongst the ACO participants, including circumstances where a nonprofit model is used. ACO participants must hold 75 percent of voting board positions. Each ACO participant is to appoint a specific entity delegate to represent it on the ACO board. In addition, the board must include one or more disinterested representatives of the Medicare beneficiary community served by the ACO.

The final rules are particularly helpful to the extent that they add additional flexibility (from the proposed rules) to the required governance structure of an ACO, including one formed through a nonprofit model. For example, the level of required proportionate representation on the ACO board has been scaled back. Rather than requiring that a representative of each ACO participant must participate on the ACO board, it will be sufficient that the ACO participants or their representatives have "meaningful participation" in the composition and control of the ACO entity's board. The final rules do not define "meaningful." In addition, a limited exception is provided to the core requirement that ACO participants hold 75 percent of voting board positions and that the board include one or more disinterested representatives of the Medicare beneficiary community. This exception is available where the ACO can demonstrate that it can, through a different governance structure, continue to involve ACO participants in innovative

<sup>41</sup> Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations, 76 Fed. Reg. 67802 (Nov. 2, 2011).

ways in governance, and provide a meaningful opportunity for ACO beneficiaries to participate in governance. Also, helpful clarification is provided on the role of the ACO board in providing oversight and strategic direction. Specific areas for board oversight are identified as care delivery, promotion of evidence-based medicine, patient engagement, quality and cost reporting, care coordination, distribution of shared savings and establishment of clinical and administrative systems, among other duties. In this regard, the rules confirm that the board members owe fiduciary duties to the ACO. The board's assigned duties appear consistent with the general scope of duties of a nonprofit board, but with the added twist of specific responsibility to assure that the organization achieves the unique purposes of the ACO.

In this regard, the IRS has issued guidance on how certain types of ACOs (such as nonprofits) might qualify for tax-exempt status (e.g., those serving Medicare and Medicaid beneficiaries, exclusively).<sup>42</sup>

## 10. Defalcation

A subtle but important trend in 2011 was the extent of fraud and embezzlement committed *against* nonprofits hospitals and health systems, especially by corporate officers and other members of management. As many health lawyers know, the IRS Form 990 contains a specific question in Part VI<sup>43</sup> inquiring whether the organization experienced any incidents of defalcation. The question itself reflects the increasing incidence of such activity in the nonprofit sector. A series of 2011 examples reflect the breadth and extent of such activity, the negative impact it has on the organization and the sector as a whole, and the need for the board to assure that appropriate internal controls are in place to limit exposure to defalcation.

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Perhaps the most prominent 2011 reported incident of nonprofit sector defalcation was the federal criminal conviction of the former general counsel of a leading children's medical center.<sup>44</sup> In July, the former executive pled guilty to charges of mail fraud, money laundering and filing a false tax return. He had been charged with creating false invoices to fictitious companies in

<sup>42</sup> Internal Revenue Service, FS-2011-11, Oct. 20, 2011 ("Tax Exempt Organizations Participating in the Medicare Shared Savings Program through Accountable Care Organizations"); see also Internal Revenue Service Notice 2011-20, 2011-16 I.R.B. 652 (April 18, 2011).

<sup>43</sup> Internal Revenue Service, "Return of Organization Exempt from Income Tax"; Part VI, Section A-5: "Did the organization become aware of a significant diversion of the organization's assets?"

<sup>44</sup> [http://www.justice.gov/usao/pae/News/2011/June/hairston\\_release.pdf](http://www.justice.gov/usao/pae/News/2011/June/hairston_release.pdf).

order to embezzle approximately \$1.7 million from the medical center, in order furnish an allegedly extravagant lifestyle and to purchase luxury goods. He received a four-year sentence.

Another prominent health care sector incident of defalcation was the March indictment of the former president of a leading college of medicine and biosciences, on federal criminal charges that she embezzled over \$1.5 million from the medical college.<sup>45</sup> The charges, which are unproven as of this date, include those relating to forged approvals for bonus payments, the submission of fictitious expense reimbursement forms, and claiming for personal tax purposes charitable contributions made with medical college funds.

A similar incident involved an investment adviser's long-running fraudulent money laundering scheme that resulted in a loss of over \$7.5 million from the executive retirement fund for executives of a large regional nonprofit health system.<sup>46</sup> The investment adviser pleaded guilty in October to charges of mail fraud and money laundering, admitting to transferring funds from the retirement account for his own use. While many companies were victimized by the scandal, the health system's loss was the largest.

Only recently (in an ongoing development) the vice president/corporate services of a university medical center resigned after what news reports described as a "routine audit" uncovered evidence of financial improprieties.<sup>47</sup> Those news reports also state that the medical center is cooperating with an ongoing federal investigation.

From a larger perspective, an international accounting firm published in 2011 a report analyzing patterns of fraud committed against corporations, and identified

the profile of a typical organizational "fraudster." The report predicted a significant increase in fraud and embezzlement due to current and increasing economic difficulties.<sup>48</sup>

These examples are reflective of a much broader and highly disconcerting trend in the nonprofit sector and in hospitals and health systems in particular. While no level of compliance plan or board oversight can serve to prevent instances of defalcation, both the board and the organization's compliance and internal audit managers should be sensitized to the trend, increase awareness of warning signs, and expand internal controls and related efforts to reduce organizational exposure. This is especially the case with respect to senior executives, and outside investment and retirement plan advisers.

## Conclusion

2011 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 nonprofit system structures, closer scrutiny of the business judgment of nonprofit board members, the impact on nonprofit governance of the transitional economy, and increased state involvement in scrutinizing business transactions.

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' strongly held view, 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.

<sup>45</sup> <http://www.justice.gov/usao/mow/news2011/pletz.ind.html>.

<sup>46</sup> Molly Gamble, "Sentara Healthcare Loses \$7.6M to Fraudulent Investment Adviser."

<sup>47</sup> "Lubbock Hospital VP Quits Amidst Embezzlement Audit," <http://www.statesman.com/news/texas/lubbock-hospital-vp-quits-amid-embezzlement-audit-2061960.html>.

<sup>48</sup> "Who is a Typical Fraudster?" <http://www.kpmg.com/us/en/issuesandinsights/articlespublications/pages/typical-fraudster.aspx>.