

Health Alliance and Intra-System Fiduciary Duties

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Despite its unique facts, the September 30, 2008, decision in the closely watched *Health Alliance* appeal may have, if widely adopted, significant implications for many parent-affiliate relationships in the nonprofit sector.¹ The Ohio Court of Appeals' crucial holding—that a fiduciary duty was owed under the circumstances of this particular joint operating arrangement—breaks new, but not totally unexpected ground. Nevertheless, it has the potential for creating significant challenges for health systems that have not adequately structured their corporate governance documents to address the key charitable mission/fiduciary duty issues reflected in this case. Moreover, its application to systems already experiencing tension amongst corporate partners could lead to increased structural instability. Accordingly, parent corporations are well advised to consider the issues raised by the Court of Appeals and position their respective system governing documents to address parent-affiliate relationships with clarity and foresight. Failure to do so could threaten the cohesiveness of the system and jeopardize the benefits sought to be achieved through system creation.

¹ *Health Alliance of Greater Cincinnati v. Christ Hospital*, 2008 – Ohio – 4981, Sept. 30, 2008 (In the Court of Appeals First Appellate District of Ohio, Hamilton County, Ohio).

Background

The *Health Alliance* case involved the structure of, and participants in, a joint operating agreement (JOA) that formed what, at the time, was thought to be the largest healthcare delivery network in the Cincinnati/Northern Kentucky area. The catalyst for the controversy was the action filed by Health Alliance, the joint operating company (JOC), to prevent the withdrawal from the JOA of two of its “Participating Entities,” The Christ Hospital (TCH) and St. Luke Hospitals (SLH).

At its core, the dispute appears to have centered on competing visions of what the JOA was intended to create. In the view of TCH and SLH, the structure was a confederation of hospitals, each with a retained responsibility for carrying out its own charitable mission within the structure of the JOA and the right to withdraw if that charitable mission was compromised by the JOC. To the contrary, the JOC appears to have viewed the structure as an integrated system with an overriding system purpose under its control. To the authors, the failure to resolve and address these competing visions in the underlying governance documents is the root of the conflict and a fundamental message to organizers of such structures.

A review of the key provisions of the JOA demonstrates both its uniqueness and largely explains the result reached by both the trial and appellate courts. First and foremost, the JOA expressly authorized a Participating Entity to withdraw from the arrangement upon an uncured event of default. The significance of that provision must be considered in connection with several other key terms of the JOA and the Master Trust Indenture (MTI), including: (a) the right of a Participating Entity, through its governing board, to exercise ultimate responsibility for the satisfaction of its charitable mission and related obligations; (b) the right of a Participating Entity to receive and review financial and operating reports from the JOC to monitor the JOC’s performance of its obligations under the JOA; (c) the right of the Participating Entities to approve the sale, lease, or disposition of their major assets; (d) the right of the Participating Entities to approve the issuance of notes under the MTI; and (e) the obligation of the JOC to operate the JOA/Health Alliance at all times in a manner consistent with the charitable missions of those Participating Entities.

Both TCH and SLH independently determined that they were being prevented by the JOC from pursuing their respective charitable missions, declared an “event of default” under the JOA, and sought to withdraw on the basis that Health Alliance had failed to cure the default. TCH’s articulated reasons for invoking the withdrawal right included both specific breaches of the JOA and MTI on the part of the JOC and mission-related claims that the JOC was impeding TCH from fulfilling its charitable mission. SLH similarly claimed uncured events of default under the JOA and breaches of fiduciary duties by the JOC.

In April 2007, the trial court (the Ohio Court of Common Pleas)² ruled that both TCH and SLH were entitled to end their participation in Health Alliance pursuant to: (a) the operation of specific provisions in the JOA and (b) Health Alliance’s breach of the fiduciary duty it owed to the two hospitals. The instant case arose from an appeal by Health Alliance of the trial court decision.

Appellate Decision

On appeal, Health Alliance argued that the trial court committed errors in two main ways. First was the decision to permit TCH to withdraw based upon its “good faith belief” that an event of default had occurred, instead of requiring proof of an actual event of default. (Health Alliance argued that there was no proof that TCH did not or could not fulfill its charitable mission at any time, nor was there any proof that Health Alliance had actually prevented TCH from fulfilling that mission.) Second was the finding that Health Alliance not only owed a fiduciary duty to TCH, but also that it breached that duty and that such a breach constituted a separate basis for withdrawal. (Health Alliance argued that it owed no such fiduciary duty to its Participating Entities.) In its September 30 decision, the Court of Appeals affirmed the trial court’s decision as to both bases for the parties’ withdrawal from the JOA.

Withdrawal Rights: The Court of Appeals’ perspective was that the terms and conditions of the JOA preserved significant autonomy for the Participating Entities. In particular, it interpreted Section 6.03 of the JOA as giving the TCH board the authority

² *Health Alliance of Greater Cincinnati v. Christ Hospital*, Ohio Ct. Com. Pl. No. A0601969, April 16, 2007.

to determine that the Alliance failed to fulfill its duty under that Section to operate consistent with TCH's charitable mission. The Court of Appeals observed that the TCH board pursued a process, carried out in good faith, that resulted in a determination that Health Alliance had indeed defaulted on its Section 6.3 obligations by jeopardizing TCH's ability to fulfill its charitable mission. This process included the TCH board task force investigation, several reports of an outside consultant, the perspectives of allied medical personnel, the opinion of legal counsel, and the input of board members.

Fiduciary Duty: The Court of Appeals was similarly supportive of the fiduciary duty claim. Applying definitions under Ohio law of "fiduciary" and "fiduciary relationship," it concluded that the Health Alliance was in a position of a fiduciary to its Participating Entities, and that it owed them—including TCH and SLH—a duty to act for their benefit, or at least not to actively harm them (to "exercise the utmost good faith and honesty in all dealings and transactions related to" the Participating Entities). This duty was determined to have been breached in multiple ways that affected the ability of TCH to carry out its charitable mission. The Court of Appeals reached similar conclusions with respect to SLH's decision to withdraw from the JOA and with respect to Health Alliance's breach of its fiduciary relationship with SLH.

Analysis

The Court of Appeals' decision should be regarded as consisting of two main components. First are those aspects of the decision—principally relating to the ability to affect withdrawal pursuant to JOA terms—that are fact-specific to this joint operating agreement. While unique to this case, they, nonetheless, serve to focus on the key underlying issue that will likely control any ultimate decision in similar cases involving a conflict between the participating entity and the parent, i.e., whether the participating entity functions as part of an integrated system with a system-wide unity of purpose that supersedes individual charitable missions or whether the affiliates function as a limited confederation of independent entities with a primacy of their individual charitable missions.

Second, where the confederation of independent entities model is used (particularly through the JOA structure), the court's decision as to the creation of a fiduciary

relationship may well have national importance and broader implications to nonprofit health systems organized on a parent/affiliate basis.

As such, we draw the following conclusions from the court's holding:

1. The court clearly viewed the entire JOA arrangement as a form of limited confederation that appears to have anticipated the potential for withdrawal by one or more hospital members. Of particular significance were those JOA provisions that worked to preserve the autonomy of the Participating Entities; e.g., protections with respect to charitable mission and the withdrawal rights. Those are certainly transaction-specific terms, and the decision of the court to support the right to exercise the unique withdrawal rights contained in the Health Alliance JOA should not be interpreted as a fundamental defect in joint operating agreement structures in general.
2. It seems clear that from a JOC viewpoint, the Health Alliance JOA would have benefited from terms that provided for a common charitable mission amongst its Participating Entities and similar system-wide obligations. Such provisions may require more difficult negotiations in the formative stages of JOA development. However, the presence of a uniform charitable mission amongst all system participants can go a long way toward defusing the types of arguments that TCH and SLH successfully made as to how Health Alliance decisions frustrated their own respective charitable purposes.

Conversely, from a Participating Entity viewpoint, and assuming the intent is to enter into a limited confederation model, the mission-related and withdrawal terms provided in this JOA serve to guarantee the Participating Entity's independent charitable mission within such a model.

3. There appears little doubt that neither the trial court nor the Court of Appeals viewed Health Alliance in a sympathetic light. To the contrary, certain actions of the JOC, which may have been internally justified as proactive steps at the time, clearly offended both the trial and appellate courts. Principal among these were: (a) ignoring the "cooling off period" mandated under the JOA and initiating the litigation within that period; (b) using "enormous sums . . . of monies . . . from the revenues of the

participating hospitals on pursuing (the) lawsuit while denying TCH and SLH access to their own revenues to mount their case”; and (c) attempting to encumber TCH with \$220 million in debt without its consent and in violation of the MTI.

4. Clearly, those portions of the decision of broadest health system relevance are those that speak to: (a) the existence of a fiduciary duty between Health Alliance and its hospital members and (b) the types of conduct that caused a breach of that fiduciary duty. Perhaps for the first time we now have a state appellate court decision standing for the proposition that fiduciary relationships do exist in the context of parent/affiliate relationships in at least some forms of nonprofit hospital corporate structures. Thus, all parent/affiliate based nonprofit healthcare systems may benefit from a review of these specific lessons from *Health Alliance*.

- (a) For example, the definitions under Ohio law of both “fiduciary” and “fiduciary relationship” relied upon by the Court of Appeals are generally consistent with the definitions of these terms under the laws of many other states. The description of fiduciary relationship applied by the Court of Appeals (“ . . . when special confidence and trust is reposed in the integrity and fidelity of another . . .”) incorporates a theme commonly reflected in the common law.

- (b) The factors considered by the court as evidencing a fiduciary relationship are normal and customary for many nonprofit health systems, including maintenance of substantial overall operational responsibilities by the parent and reserved powers that in effect maintain full operational control.

- (c) Particularly instructive are the types of parent organization conduct that the Court of Appeals found to have breached that fiduciary relationship in the confederation model, including:

- Constraining TCH’s ability to compete in the future by denying it access to its revenue stream and by restricting its operational control, while at the same time pursuing a campaign to pay bonuses to physicians who agreed to execute noncompetition agreements to restrict TCH’s future access to those physicians;

- Using TCH funds to finance Health Alliance strategic planning, while prohibiting, TCH, for example, from engaging in any strategic planning on its own behalf;
- Initiating the declaratory judgment action in contravention of a sixty-day cooling off period; and
- Expending “enormous sums” from the revenues of the Participating Entities to prosecute the litigation while, at the same time, denying TCH and SLH access to their revenue to pay for legal fees.

In the context of the unique *Health Alliance* facts, these particular actions appear clearly indefensible. However, they should be viewed in the broader context of parent/affiliate relationships. In such relationships, the parent is, on occasion, called upon to make difficult decisions that may disadvantage a particular affiliate, but are intended to serve the entire system. In such instances, the existence of an overriding, system-wide unity of charity purpose will, we believe, be critical in permitting effective decision-making at the parent level. An open question remains, however, as to how much operational primacy an affiliate board may cede without violating any applicable state law requirements, with respect to exercising ultimate authority over corporate decision-making.

Conclusions, Recommendations

It is important to emphasize that *Health Alliance* is based upon a unique set of circumstances (i.e., the specific terms of the JOA). Furthermore, nothing in the opinion can fairly be interpreted as undermining the basic legal feasibility of the joint operating company model. Nevertheless, the decision has potentially broad implications for the formation and administration of nonprofit health systems. System-type organizational structures that involve parent organizations seeking to control independently incorporated nonprofit affiliates (which have their own “legal” governing boards and

separate definitions of charitable mission) are increasingly subject to allegations of institutional conflicts of interest.³

The *Health Alliance* decision serves as a “wake-up call” to the issues that can arise where the fundamental charitable mission of the operational model is not clearly defined in the originating governance documents and/or are subject to conflicting interpretations. Moreover, the failure to establish a primacy of the “system” purpose can effectively undermine the model and cause significant fiduciary duty issues to arise with respect to the obligations of the parent to the affiliate. Systems should therefore give greater attention to the adoption of a uniform charitable mission for all system entities, the difficulties of adopting such a mission notwithstanding. These and similar steps may help assure the continued effectiveness of the model given the potential for *Health Alliance*-type challenges.

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³ These tensions are increasingly leading to litigation amongst the participating entities; see, e.g., *Lifespan Corporation v. New England Medical Center, Inc. and New England Medical Center Hospitals, Inc.*, United States District Court for the District of Rhode Island, C.A. No. 06-421-T-OLM