During the more than four-year period that followed the enactment of the Sarbanes-Oxley Act of 2002, the landscape of organizational governance has decidedly shifted for all healthcare systems, including nonprofit companies. Significant challenges are now faced on the adoption of best governance practices for nonprofit entities. These forces for reform have come from all sectors of government, and the courts. Some measures being advocated go to how a nonprofit healthcare system undertakes its mission as a charitable, tax-exempt, organization. Every healthcare lawyer now faces new challenges in advising clients on how best to structure, and implement, organizational governance, including adherence to the nonprofit entity’s mission.

The American Health Lawyers Association is pleased to welcome back panel members for Part II of the roundtable series “Current Perspectives on Healthcare Governance: A Roundtable Discussion Among Experts.” In Part I of this roundtable series, which appeared in the January 2007 issue of Health Lawyers News, the panel addressed the unique structural dynamics of nonprofit healthcare entities, and how best to guard against, and respond to, government investigations and prosecutions.

Part II of the roundtable series will focus on state Attorneys General initiatives against nonprofit organizations, as well as federal oversight, and prospects for reforms. Additionally, challenges to tax-exempt status and efforts to mandate levels of charity care will be discussed.

Our panel members are Andrew J. Demetriou (Fulbright & Jaworski LLP), Lois Dehls Cornell (Senior Vice President and General Counsel of Tufts Health Plan), Ronald H. Levine (Post & Schell PC), Gerald M. Griffith (Jones Day), and James R. Schwartz (Manatt, Phelps & Phillips LLP). Stuart I. Silverman (Chair of AHLA’s Corporate Governance Task Force) is the moderator.

Mr. Silverman: Welcome to the panel, Mr. Schwartz. We have seen some fairly aggressive enforcement initiatives by state Attorneys General against the nonprofit healthcare sector. The cases brought by the Attorney General for the State of Minnesota, Allina and Health Partners, come to mind. Explain for us what those cases were about.

Mr. Schwartz: Stuart . . . you are absolutely correct, both the Allina and Health Partners cases reflect very aggressive enforcement actions by Minnesota Attorney General Mike Hatch. Interestingly, both arose out of “compliance reviews” conducted by the Minnesota AG’s office. As you know, in many states the state Attorney General has broad charitable trust jurisdiction over nonprofit organizations operating within the state and has the legal authority to conduct oversight reviews to ensure that the organization is operating in a manner consistent with the law.

Mr. Silverman: Well, let’s focus first on the Allina case. There were widespread abuses uncovered by the Minnesota Attorney General.

Mr. Schwartz: Yes, the Allina case had its genesis in a January 2000 federal audit report about problems at nine HMO’s around the country, including Medica—a subsidiary of Allina. In early 2001, Attorney General Hatch commenced an extensive “compliance review” that lasted 1½ years and resulted in a six-volume report—documenting a wide range of alleged improprieties relating to travel and entertainment expenses, executive compensation and perquisites, executive bonuses, and consultant agreements.

Mr. Silverman: The state Attorney General was criticized for exceeding his authority in his handling of the Allina investigation. How was Allina resolved?

Mr. Schwartz: The end result was a Memorandum of Understanding between Allina and the Attorney General that essentially restructured the company, requiring the spin-off of the Medica HMO subsidiary and substantial...
changes in Allina’s internal policies and procedures relating to corporate governance. While the initial investigation was roundly praised in terms of its thoroughness, there were some who were concerned that the Attorney General had gone beyond his appropriate oversight role in compelling a restructuring of the company and, reportedly, personally recruiting board members for the newly independent Medica HMO. The concern raised in this regard was whether the state Attorney General was acting to enforce existing laws or was, instead, seeking to exercise personal control over a private nonprofit corporation by, in essence, appointing its board of directors.

Mr. Levine: I would note that similar concerns about the limits of the role of the prosecutor have been voiced at the federal level and in the for-profit world as well. For instance, in the context of a federal investigation of accounting fraud and a subsequent deferred prosecution agreement, both the U.S. Attorney for the District of New Jersey and his federal monitor actually attended a Bristol Myers Squibb (BMS) Board meeting after which the BMS CEO was replaced reportedly at their urging. The wisdom of prosecutors assuming the roles of quasi-regulator, legislator, or even business executive merits further public debate.

Mr. Silverman: I understand that Attorney General Hatch’s stance vis-à-vis his choice of board members for Allina was resolved by the court.

Mr. Schwartz: Yes, the matter came to the forefront when Attorney General Hatch subsequently had a falling out with his personally recruited Medica board in 2001 and sued its members seeking their removal and claiming that they had “hijacked the company.” In a decision issued on August 17, 2005, Judge Lloyd Zimmerman of the Hennepin County District Court rejected the AG’s claims, and held that all of those claims were unproven and without merit. Moreover, with respect to the Medica directors, Judge Zimmerman wrote, “At the end of the day, good people were unfairly accused. After a fair and impartial trial their good name is restored to them.” While Judge Zimmerman praised Attorney General Hatch’s initial investigation, he was highly critical of the Attorney General’s subsequent challenge to the board’s self-governance.

Mr. Silverman: Mr. Schwartz, in terms of remedial measures imposed as a result of the settlement with the Attorney General, what was Allina required to do aside from the spin-off of the Medica subsidiary, and the acceptance of new board members? I presume real operational changes were imposed.

Mr. Schwartz: The MOU between the Attorney General’s Office and Allina, as well as Medica, is quite extensive, including a number of operational changes. Some of the more salient provisions include new policies for executive compensation, incentive and separation agreements, and restrictions on executive expense reimbursements (including new prohibitions on recreational club memberships). Others pertain to new conflict of interest and ethics policies, new policies for third-party contracts, and limits on other type expenses. The MOU also touches on new policies regarding for-profit ventures and limits on equity interests by officers and employees. There is also a provision providing access by key employees, other than the CEO, to the board chair.

Mr. Silverman: What were the specific legal theories relied upon by Attorney General Hatch in his action against Allina?

Mr. Schwartz: Attorney General Hatch never filed a legal action against Allina charging the company or its officers and directors with any substantive wrongdoing. Rather, his lawsuit was to obtain access to documents and records that he had requested from the company and which had not been provided. However, his Compliance Report spoke in terms of waste of charitable assets and inurement, although those issues were never litigated and no finding of legal liability was ever made. The dispute over these issues was resolved through the MOU.

Mr. Demetriou: There are some parallels in this case to the remedy fashioned by the Hawaii Attorney General in the Bishop Trust case. Among other measures imposed on the charity was a wholesale change in the composition of its board of trustees and the adoption of policies that would prevent self-dealing transactions.

Mr. Schwartz: Andy is correct that similar remedies were sought and obtained in the Bishop Trust case. In the Bishop Trust matter, it should be mentioned that the IRS played a major role in threatening to challenge the tax-exempt status of the Trust if such organizational changes were not implemented. In that case, the combination of IRS enforcement pressure and a court action by the state Attorney General caused the ultimate result.

Mr. Silverman: Then there was the Health Partners case. What was that about? I understand that Attorney General Hatch was also criticized in that matter in the exercise of his authority.

Mr. Schwartz: The Health Partners case also began as a compliance review and focused on allegations related to executive compensation, outside consultant contracts,
travel and entertainment expenses, and board oversight of these matters. These are, of course, appropriate issues for Attorney General oversight, and would not make the inquiry unique. However, once again, as you suggest, Attorney General Hatch went beyond the normal enforcement model and filed suit to compel the appointment of two additional members to the Health Partners board—both hand-selected by him—predicated on his claim that they were needed to supplement the business expertise of the board. Lacking any express statutory authority to “appoint” (as distinguished from seeking “removal of”) board members, Attorney General Hatch sought to have his appointees named as “Special Administrators” with powers to act as trustees.

Mr. Silverman: How was the matter resolved with Health Partners?

Mr. Schwartz: While the Health Partners board initially opposed the Attorney General’s demand, in the end a compromise was reached which allowed the appointment of a single individual as a Special Administrator with certain advisory rights. However, again the issue arises as to the appropriateness of the state Attorney General, as the regulatory official with oversight over charitable organizations, intervening to impose his choices for board membership on private nonprofit corporations. This has raised concerns with respect to possible conflicted loyalties on the part of such directors, political interference in the governance of private nonprofit organizations, and the blurring of the role of the Attorney General in terms of operating as a regulatory agency objectively enforcing the law versus operating as a “super-trustee” controlling board appointments to such organizations. These are issues that engender substantial debate within the nonprofit community.

Mr. Griffith: Minnesota is not alone in the field of far-reaching attempts to regulate nonprofit operations. Just last year, Ohio’s then Attorney General Petro proposed and later withdrew a very expansive set of regulations. The proposed regulations, among other things, would have effectively compelled (or coerced) nonprofit organizations to adopt a new model executive compensation, expense reimbursement, and conflicts of interest policies. Those model policies included supermajority approval requirements and went so far as to state that as a general rule, any compensation in excess of thirty times the federal minimum wage generally would not be in furtherance of charitable purposes. What was perhaps most unique about the Ohio situation is that unlike the Health Partners case, these were remedial measures being proposed without the benefit of any investigation of alleged abuses at any nonprofit organizations.

Mr. Silverman: Mr. Schwartz, aside from the push to restructure the board, what remedial steps were implemented by Health Partners that arose from the investigation? I presume there were expenditure restraints imposed.

Mr. Schwartz: Yes, that is correct. In response to the Attorney General’s Compliance Report, Health Partners reportedly became more strict about travel and entertainment expenses, eliminated country club memberships, and simplified its bonus and compensation packages.

Mr. Silverman: You mentioned that it was highly unusual, and, in your opinion, unwise, for AG Mike Hatch in his investigation of Allina and Health Partners to have reportedly personally involved himself in the selection of board members. I presume, though, that most state laws empower the state AG to seek judicial approval to have a receiver or other third party appointed by the court where there is strong evidence of malfeasance by board members, and asset waste. Would you agree?

Mr. Schwartz: Stuart, that is correct. State Attorneys General have broad discretion to seek appropriate remedies through the courts when they believe that charitable assets have been misused and are at substantial risk. Among these remedies are injunctive relief to protect charitable assets, seeking the removal of directors and trustees, the appointment of receivers to assume operational control of the organization, and, in the most egregious cases, the involuntary dissolution of the charitable corporation, and the distribution of its assets to a successor charitable organization. However, in each of these instances, the ultimate decision is left to a court and is based on the evidence in the case. The concern that I have raised with Allina and Health Partners relates to the risk of politicizing the process and having a regulatory official seek to appoint members of the board of a private charitable organization without any legal authority to unilaterally do so.

Mr. Demetriou: While we are discussing enforcement initiatives by state AGs, let’s not forget about the ruling by the New York Supreme Court just several months ago in the litigation spearheaded by Attorney General Eliot Spitzer against Grasso, former CEO of the New York Stock Exchange.

Mr. Silverman: Well, in that case, the state court decision pertained to the fiduciary duties of Mr. Grasso and his executive compensation package while the New York Stock Exchange was a nonprofit entity, before it went public. What lessons can be learned from that case for nonprofit companies?
Mr. Demetriou: In my opinion, the New York Stock Exchange case is sui generis. Since it was a mutual benefit corporation, rather than a public charity, in most states other than in New York, the Attorney General would not have had jurisdiction over its activities. Further, it was the extraordinary levels of compensation awarded to Mr. Grasso, rather than issues of process or director misconduct, that appear to have been the key factor in the decision to bring the case at all. While there are allegations that details of Mr. Grasso’s compensation package were either concealed from, or not understood by the board of directors, and these allegations may ultimately be proved, the “lessons” in that case may be that boards need to exercise vigilance in understanding and approving large and complex compensation arrangements.

Mr. Silverman: Mr. Schwartz, let’s focus on today’s governance environment at the state level nationally. What are the most important governance issues you can suggest to a nonprofit board going forward, to steer the organization in ways that would negate, or lessen, negative impacts of any inclination by a state Attorney General to conduct inquiries of governance practices?

Mr. Schwartz: There are several points to make here. It is important to recognize that state Attorneys General take their obligation to oversee the activities of nonprofit organizations very seriously. If they are not convinced that the nonprofit organization’s board of directors/trustees is exercising effective oversight, they are much more likely to conduct their own oversight investigation. As a result, the elements that tend to reassure them that an AG compliance review is not necessary include an engaged, independent board of directors; appropriate board committee oversight over “red flag” issues, including executive compensation and perquisites, travel and entertainment costs, conflicts of interest and related party transactions, and “mission compliance.” In addition, institutional transparency with respect to governance can avoid problems based on a misunderstanding of the facts. Moreover, where issues arise, but an organization’s board can demonstrate that it is on top of the problem and dealing properly with it, most state Attorneys General are inclined to rely on the board to do its job and not institute a full compliance review. Where, however, the board’s action does not give the Attorney General comfort that effective oversight has taken place, investigations are much more likely.

Mr. Silverman: Can you recommend for us the types of structures that nonprofit healthcare companies should strive to adopt to ensure more competent governance? Things that immediately come to mind are independent committees and internal controls.

Ms. Cornell: In my opinion, the New York Stock Exchange case is sui generis. Since it was a mutual benefit corporation, rather than a public charity, in most states other than in New York, the Attorney General would not have had jurisdiction over its activities. Further, it was the extraordinary levels of compensation awarded to Mr. Grasso, rather than issues of process or director misconduct, that appear to have been the key factor in the decision to bring the case at all. While there are allegations that details of Mr. Grasso’s compensation package were either concealed from, or not understood by the board of directors, and these allegations may ultimately be proved, the “lessons” in that case may be that boards need to exercise vigilance in understanding and approving large and complex compensation arrangements.

Mr. Schwartz: Well, first and foremost, people count. Having a strong, independent board of directors made up of individuals with diverse skills and backgrounds is the most important factor in good governance. In addition, it is crucial to have appropriate committee structures and compliance programs in place. As you know, in California many large nonprofit organizations are now required to have audit committees made up of wholly independent persons (although California law excludes non-corporate entities such as a trusts, hospitals, educational institutions, and religious and governmental entities). Similarly, given the current regulatory focus on executive compensation, perquisites and travel and entertainment, we also strongly recommend independent compensation committees. These committees should have written charters that make clear the extent of their responsibilities; they should have the authority to retain independent outside auditors and consultants; and they should be made up of individuals with sufficient background and financial skills to effectively carry out their responsibilities. Finally, it is important that there be adequate compliance programs and appropriate board oversight of the internal audit function.

Ms. Cornell: Ms. Cornell, from an in-house perspective, what are your thoughts about oversight duties by nonprofit governing bodies.

Ms. Cornell: Stuart, in my view, it is important to note that the board’s oversight of an organization’s compliance program is continuing to take a more central role in board governance obligations. Not only should boards have a structure in place to make sure the organization has an adequate compliance program, but boards must undertake responsibility to make sure the program is alive and well: an active working program. This standard was set in the 1996 decision by the Delaware Chancery Court in the Caremark International case. In that case, the court not only articulated the board’s fiduciary duty to ensure a compliance program is in place, but also noted that failure to reasonably oversee the compliance program could result in liability. At the end of last year, the Delaware Supreme Court in Stone v. Ritter confirmed Caremark and took it to another level, setting forth specific conditions for director oversight. That case, together with the tone set in DOJ’s recent guidelines in the McNulty Memorandum, which also confirms board obligations for compliance program oversight, should provide all of us with a heightened sense of this important governance obligation. DOJ’s latest memorandum, “Principles of Federal Prosecution of Business Organizations” was issued in December, 2006.
Mr. Silverman: Mr. Schwartz, back to you. We hear a lot about the need to guard against conflicts of interest. In your view, what best efforts can a nonprofit healthcare system make to lessen the chance of conflicts of interest arising in the decision-making process? Are there ways to promote independence in decision making?

Mr. Schwartz: Again, transparency and process constitute the first line of defense. Of course, every organization should have a written conflict of interest policy—for both board members and senior management—and detailed disclosure forms so that any potential related party transaction is identified in advance. Moreover, it is crucial that there be a process (preferably computerized) to monitor and insure that any related party transaction is identified in advance. Only in this way can organizations obtain the benefits of the “rebuttable presumption of reasonableness” under the Internal Revenue Code or comply with state statutes like California Corporations Code § 5233. In addition, it is important to recognize that non-financial conflicts of interest exist and, as a result, conflict of interest disclosure forms should be broad enough to cover such relationship conflicts as well. Without such a system, it is not possible to effectively identify and properly “vet” transactions which may create conflict issues.

Mr. Demetriou: The issue of dealing with “non-financial” conflicts of interest is especially difficult. In part there are no legal guidelines to define the scope of these conflicts and thus crafting policies and disclosure forms that will address prospective conflicts present challenges. If the applicable standard for a non-financial conflict is whether the judgment of a director might be impaired due to relationships with another director that are external to the corporation’s affairs, then exploration of possible conflicts could require a very intrusive questionnaire, and certain directors may not respond favorably to the inquiries.

Mr. Levine: Nonetheless, the point about seemingly indirect or non-financial conflicts is an important one. A complete conflicts policy should reach: interests in adverse litigation; gifts and gratuities; outside activities (“conflicts of commitment”); nepotism; and use of confidential or proprietary information.

Mr. Silverman: Much focus has been on the make-up of the board of directors. What steps can a nonprofit company take to instill greater discipline, and expertise, in the board?

Mr. Schwartz: Stuart—this is an excellent question. Key, of course, is the recruitment and training and education of board members. Diversification of skills and background usually makes for a stronger board. It is also essential (and, in California, required by law) to have a majority of the board be disinterested persons. Finally, it is important to provide those board members with the information and training they need to effectively carry out their responsibilities. In this regard, governance training, education about the goals and mission of the organization, and understanding of unique issues that the organization may face—including endowment fund restrictions, mission restrictions, etc.—are all crucial if the board is to effectively carry out its oversight responsibilities.

Mr. Silverman: Mr. Griffith, let’s turn our focus now to tax and related issues. We have seen that nonprofit hospital systems have been under increasing pressures from state and local governments, as well as at the federal level, to justify their tax-exempt status. Just briefly, how would you best describe these challenges going forward? It seems there will be continuing pressures from these levels of government.

Mr. Griffith: Stuart, you are right, the pressure is increasing. I think the recent past is indicative of what the future holds for nonprofit healthcare. The platform may shift somewhat from the federal more to the state level, but the message will be similar. Hospitals will be repeatedly called on to justify their exemption, and there will be increasing pressure to do so in a way that can be measured on an apples-to-apples basis. Those demands will seem impossible to reconcile with the varying community benefit missions of nonprofit hospitals, with different mixes of research, teaching, Medicaid and indigent care, low margin services, chronic disease management services, etc. The CHA/VHA community benefit guidelines provide a useful baseline for developing more of a common reporting language for community benefit, but there still will be differences in how one hospital and another accomplish their community benefit missions. A key challenge will be to make the relevant constituencies understand that comparing different community benefit programs is a bit like comparing apples and oranges. On some level it is all fruit and all nutritious in its own way.

As for how long this debate will continue, suffice it to say there is no end in sight yet. The pressures will continue for at least as long as nonprofit hospitals continue to have a communication gap and as long as significant segments of their communities are uninsured and have unmet healthcare needs.

Mr. Silverman: What is the nature of the activity at the local level? Also can you explain for us some of the major administrative and court challenges that have been brought, and those currently pending?
Mr. Silverman: You mention the Wexford Medical Group case. There, a medical clinic owned and operated by a nonprofit entity sought review before the Michigan Supreme Court of a decision by the state’s Tax Tribunal denying, for a two-year period, a property tax exemption to the clinic, finding that the clinic was not a “charitable institution” under state law. The clinic appealed that decision to the court of appeals, which affirmed the denial of the property tax exemption. In support of its decision, the court of appeals made particular note that the clinic under its charity care program during the two years rendered care to 13 patients at a value of $2,400. The appellate court found that the provision of charity care amounted to nothing more than an “incidental part of its operations.” The court was also not persuaded by the clinic’s losses associated with treatment of Medicare and Medicaid patients, and emphasized that the clinic’s aim was to become profitable. All of this led the court of appeals to conclude that the clinic was not a charitable institution, and thus not entitled to a property tax exemption. The Michigan Supreme Court rejected outright the court of appeals’ reasoning, concluding that the clinic was indeed a charitable institution, and thus entitled to a property tax exemption. Mr. Griffith, explain for us why you believe the Wexford Medical Group case is particularly noteworthy.

Mr. Silverman: But Mr. Griffith, should we view the Wexford case in context, limited to the court’s broad reading of the term “charitable institution,” unique to Michigan’s own statute addressing entitlement to a property tax exemption for such entities?

Mr. Griffith: Of course the answer in each state will depend on what the state statutes say constitutes exempt property, but charitability is a key, if not universal, concept. Many states do have an element of “charitable” operation or use or equivalent terms in their exemption statutes. In those states, the Wexford case should be very instructive of what organizations and properties qualify for exemption.

Mr. Silverman: We have seen the decision to deny the property tax exemption for Provena Covenant Medical Center for the 2002 tax year. That decision was rendered several months ago by the Illinois Department of Revenue. There, it was determined that Provena Hospital was not an “institution of public charity,” as that...
term is defined under Illinois law. Are there troubling aspects in your view to the denial of the property tax exemption to Provena in that matter?

Mr. Griffith: Actually, there have been three recent decisions or recommendations in this case. First, in February 2004, the Illinois Department of Revenue (DOR) accepted the recommendation of the local board of review and denied exemption for Provena Covenant. Provena then requested a hearing before an Administrative Law Judge in December 2004, and the ALJ issued a very detailed opinion recommending that the DOR’s original decision be overturned and that Provena Covenant be awarded tax-exempt status. On September 29, 2006, nearly two years after the hearing, the Director of the DOR overturned the ALJ’s recommendation and denied exemption to Provena Covenant. That decision is being appealed by Provena. On appeal, the hospital is likely to allege various factual errors and errors of law. In the end, if the latest DOR decision is affirmed on appeal it could indeed have serious negative consequences for nonprofit hospital tax-exemption in Illinois and any other state that follows a narrow reading of the exemption statutes and what it means for a hospital to be “charitable.”

Mr. Silverman: In its decision, the DOR indicated that charity care policies had to be publicized to be effective, and that generally, charity care should be measured at cost. Mr. Griffith, do you take issue with this approach?

Mr. Griffith: Generally no, Stuart. There is a growing consensus that cost is a fairer way than charges to measure free or discounted care, and if no one knows about particular charity care programs they will not be used. In some hospitals, the education efforts and dissemination of charity care policies may be lagging, yet after all of the publicity over hospital billing, collection, and charity care practices recently it is difficult to believe many people don’t know enough to ask about charity care. Even if it is adequately publicized, the patients do need to make an effort, and staffs need to be trained how to respond appropriately. I will also reiterate that focusing solely on free care tends to ignore the bigger question of what it means to be charitable and how the community is benefited by the operations of a typical nonprofit hospital. The Provena Covenant decision stands in marked contrast to the independent, unanimous conclusion of the Michigan Supreme Court in the Westford case that rightly considered a range of clear community benefits provided by the clinic.

Mr. Levine: Stuart, I would also note that it’s important that hospital staff be trained to report charity care practices and community benefits accurately so that the risk of exposure to claims of misrepresentation either by donors, lenders, or the state is minimized.

Mr. Silverman: Well, Mr. Griffith, tell us how the DOR in Provena Covenant interpreted “charitable.”

Mr. Griffith: The DOR essentially interpreted “charitable” to include only free care and only where the hospital has made no efforts to collect any amount for the portion of the cost of that care that is argued to be charitable. In other words, the DOR requires that decision to be made in a vacuum before any collection efforts regardless of whether or not the patient has provided the information the hospital needs to make the determination. That is just one example of the unworkable rules that hospitals would have to follow if the DOR’s view holds sway.

Mr. Silverman: The DOR also suggested in its opinion that a dollar amount threshold be used to measure the mandated level of charity care.

Mr. Griffith: Yes, that is correct. The problem, though, is that there is absolutely no guidance in the opinion or in any case law on what the mythical amount may be. Nor does DOR even hint at the need for some part of a nonprofit hospital’s funds to be set aside for expansion, maintenance, and renovation of facilities or equipment to maintain or improve the quality of healthcare that everyone demands. This is an impossible, unknowable standard.

Mr. Silverman: Mr. Griffith, in your view, what other aspects of the DOR’s approach in Provena Covenant are troublesome?

Mr. Griffith: The DOR’s approach also completely ignores a variety of other unquestionable community benefits, such as the subsidy hospitals provide by accepting Medicaid patients on a nondiscriminatory basis, not to mention various low margin or no margin services, health education and preventive programs that directly improve the health of the community. These are all charitable activities, and that is what the statute requires. To create a free care standard out of whole cloth would inevitably lead to a reduction in these other important community benefit activities in order to keep the doors open. Whether meeting an undefined free care standard ever would be possible, even with reductions in other services, remains to be seen and it cannot even be guessed at with the open-ended approach DOR took. It would also be interesting to see DOR’s rationale for its decision if the end result is a reduction in the number of hospitals who accept Medicaid patients or maintain sole provider outposts in rural areas.
Mr. Demetriou: Such an approach also ignores the community benefit from the operation of emergency rooms by charitable hospitals as a condition of their tax-exempt status. This care is often provided to individuals of limited means at a significant financial loss to the hospital. For-profit hospitals, on the other hand, are not required to maintain an emergency room at all, and many do not.

Mr. Silverman: There seems to be a push to legislate billing and collection practices of charity care hospitals. What are the highlights of the legislation that has been enacted on this subject, and what aspects, if any, do you view as particularly troublesome for the hospital sector?

Mr. Griffith: Using two states with recent legislation as examples (Illinois and New York), some of the common elements that have been enacted include protections to delay referral to collection agencies (e.g., while financial assistance applications or insurance claims are pending), notice requirements before sending a bill out for collection, requiring notice to patients of the availability of financial assistance, setting time frames for how long a patient has to apply for assistance, prohibiting foreclosures on a primary residence or requiring hospital board approval for liens or garnishments, requiring that hospitals allow installment payments, mandating plain English billing invoices, and providing for a dispute resolution process when patients disagree over a bill. To some extent, these reforms reflect protections that may already exist under bankruptcy laws, such as protection for a primary residence under the New York legislation, but they provide those protections without the patient having to go through the bankruptcy process. In other respects, they reflect practices that are already in place, among others, at many nonprofit hospitals that subscribe to the principles of HFMA’s patient friendly billing project (summarized in various public documents on www.patientfriendlybilling.org).

Mr. Silverman: Mr. Schwartz, you wanted to make a comment?

Mr. Schwartz: Yes, thank you. Gerry is exactly correct. Assembly Bill 774 was enacted this year in California with many of the same features relating to requirements to maintain charity care and discount policies, payment limitations for eligible patients, and limitations on billing and collection practices. In fact, many of our nonprofit hospitals had already adopted policies intended to address these concerns in advance of the legislation.
Mr. Silverman: Mr. Griffith, we know about the attempt by the Illinois Attorney General last year to impose by new legislation mandated levels of charity care. That effort did not succeed. What were the specific elements of the Illinois proposed law?

Mr. Griffith: In its simplest terms, the legislation would have required Illinois hospitals to provide free care for everyone earning less than 150% of the federal poverty level and offer a sliding scale of charges for patients at 150-250% of the federal poverty level. Although that portion may not sound unusual, it was coupled with a requirement that hospitals spend at least 8% of their annual operating costs on free care. The financial impact on Illinois hospitals would have been substantial. The mere possibility of the legislation passing led bond insurers to refuse to insure any new bond issues in Illinois, cutting off access to the capital markets for many of the state’s hospitals. S&P also issued a release on the legislation in March 2006 commenting on the potential negative effects on hospital credit, other community benefits, and the ability of hospitals to maintain state-of-the-art services. It is likely, however, that the Attorney General will try again to get some charity care legislation passed in Illinois, so it may be premature to say the effort did not succeed.

Mr. Silverman: What about other state initiatives?

Mr. Griffith: Within roughly the past year, New York also adopted legislation that would restrict some hospital billing and collection activities and mandate financial aid protocols for uninsured patients with income of up to 300% of the federal poverty level. As Jim mentioned, California followed suit with legislation in October 2006 which limits charges to the uninsured who earn less than 350% of the federal poverty level, with the charges capped at the amount hospitals charge government payment programs. In Texas, one of the first states to adopt some form of charity care requirements, charity care is tied into property tax exemption with mandatory community benefit reporting. In Rhode Island, meeting minimum charity care standards based on statewide averages is a condition of licensure. A number of states also have a variety of reporting requirements for nonprofit hospitals that capture various elements of community benefit activities.

Ms. Cornell: Massachusetts has such a reporting structure in place. In 1994, the Massachusetts Attorney General created voluntary Community Benefit Guidelines for hospitals, followed in 1996 by guidelines for HMOs: the first to be issued by a state Attorney General. Hospitals and HMOs in the state must file an annual report capturing the organization’s expenditures to target the needs of the medically underserved population in their communities. The Annual Community Benefit Report creates transparency and accountability for charitable contributions of hospitals and HMOs in Massachusetts. Although they are voluntary, they create a community benefit standard for the HMO and hospital industry, have raised public awareness of contributions, and have also created an additional board oversight obligation: the Annual Community Benefits Report must be presented to and annually voted upon by the organization’s board. Overall, this report has not created an enforcement mechanism for the state Attorney General, but instead has set a standard of community giving to which Massachusetts organizations must adhere.

Mr. Silverman: Mr. Griffith, we see increased scrutiny at the federal level, from Congress and the IRS, focusing on the tax-exempt status of nonprofit hospitals. Are those efforts raising the same kind of issues that are being pressed at the state levels of government?

Mr. Griffith: The proposals and questions have a number of similarities. The law at the federal level for nearly 40 years has been a community benefit standard. A hospital can qualify for exemption if it avoids a profits interest or unreasonable compensation for insiders and it is organized and operated in a manner that provides a benefit to a sufficiently broad segment of the community. Charity care is only one factor that the IRS considers, and it is not a requirement for federal tax exemption. The IRS looks for factors such as oversight from a community board, an open medical staff consistent with the size and nature of the facility, an emergency room open to all (or a needed specialty service), participation in government healthcare programs, charity care, certain medical research activities, community health outreach activities, medical education, contributions to community health organizations, and any other activity that can be demonstrated to be reasonably expected to improve the health of the community. Activities that improve the quality of healthcare, improve access or availability of healthcare, or contain the costs (without compromising quality) of healthcare provide a community benefit.

Mr. Silverman: The IRS seems to have taken steps to enhance monitoring of hospitals.

Mr. Griffith: Yes, with the mailing in 2006 of the community benefit questionnaires to hundreds of hospitals, the IRS served notice that it intends to become more active in monitoring how hospitals are satisfying the community benefit standard. Under the Republican leadership, Congress pushed the IRS to get results quickly and share them with Congress. It remains to be seen how much
interest Sen. Baucus, Rep. Rangel, Rep. Stark, and other key Democrats will have in forcing the IRS’ hand on community benefit and other reviews of the nonprofit sector.

Mr. Silverman: There were hearings on Capitol Hill which focused on adherence by hospitals to the community benefit standard.

Mr. Griffith: Yes, that is correct. In part, the hearings were an outgrowth of allegations about billing and collection practices. Hearings were held before the Senate Finance Committee and the House Committee on Ways & Means. Those hearings focused on what hospitals do in return for their exemption, both in terms of adequacy of the current community benefit standard and in terms of what is being done by the IRS to enforce that standard. There has also been a fair amount of attention paid, at least in committee, to executive compensation, conflicts of interest, hospital pricing, and transparency in the governance of the nonprofit sector, including healthcare.

We have seen some reforms in the Pension Protection Act, such as the new prohibition on loans to certain insiders of supporting organizations (which would include many healthcare system parents), increases in potential excise taxes on management for approving excessive compensation packages, and mandated public disclosure of unrelated business income tax returns. We have also seen significant information gathering efforts, including the letters and information requests from Senator Grassley, the Government Accountability Office, and the Congressional Budget Office (the latter two both requested by Rep. Thomas) asking about various community benefit activities, joint ventures, and compensation practices. We may see more activity in this area in the new Congress, though the Democratic win in the mid-term elections may lead to a focus on other issues first in the new Congress, with more being done by the IRS and at the state level. For example, it is unclear as we have this discussion whether the Senate Finance Committee staff report that Senator Grassley requested after the September 13, 2006 charity care and community benefit hearings will be completed or lead to specific legislation. I would note though that there are no guaranties the issue is going away, and on many points Senators Baucus and Grassley appeared to see eye to eye.

Mr. Silverman: Mr. Griffith, what advice would you give the General Counsel of a nonprofit hospital, and its management, in efforts to avoid and address the threats on the horizon?

Mr. Griffith: I think there are four key steps to consider. First, get your message out early and often. Let the community know about all of the good the hospital does. Second, look at ways to improve how you track and report community benefit. It has to become part of the culture that there are certain basic operational steps that need to be done daily. Third, reexamine your conflict of interest procedures. Independent directors and committees approving transactions can add significant protections. Fourth, take a close look at the role mission fulfillment plays, or should play, in executive compensation. Financial performance is important and supports the mission, but if mission also matters for executive compensation the program is more difficult to criticize.

Mr. Silverman: Mr. Levine, you wanted to make a last point?

Mr. Levine: Yes, I think that the trends we have been talking about are fueled by Congress’ continued focus on fraud and abuse recoveries from hospitals and other providers under the False Claims Act. The healthcare sector remains under the microscope. The role of the board in “good governance” has a much wider reach than was perhaps previously believed, and it is inextricably linked to compliance issues.

CONCLUSION

Mr. Silverman: That concludes Part II of the two-part series for this roundtable discussion. I want to thank the panel members for taking the time to share with us their insights and views on the most pressing governance issues for nonprofit healthcare entities.

This roundtable series is an endeavor of the AHLA Corporate Governance Task Force. We encourage you to raise questions you may have with our panel members regarding their opinions and views by using the Corporate Governance Task Force listserv at CG@lists.healthlawyers.org