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Emerging Issue: The Dynamic Role of States in Nonprofit Healthcare

State Charities Regulation In A Dynamic Health Care Market

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INTRODUCTION

Under the common law in most jurisdictions, the attorney general as charities regulator is mandated to oversee the due application of charitable funds and to ensure that directors, trustees and other fiduciaries of public charities fulfill their fiduciary duties.[1] In the health care context, attorneys general have been called upon most prominently in recent years to apply charities law in proposed "conversions" of charitable health care entities to for-profit ownership

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[1] In Massachusetts, this duty is codified as follows: "The attorney general shall enforce the due application of funds given or appropriated to public charities within the Commonwealth and prevent breaches of trust in the administration thereof." Mass. Gen. Laws ch 12, § 8.

and operation.[2] In addition, questions have been raised as to the consistency of certain compensation arrangements with the due application of charitable funds and with fulfillment of fiduciary duties. For example, high executive or physician compensation packages have been questioned as potentially inconsistent with fiduciary duties owed by the executives and the board members approving such arrangements. Compensation and other arrangements between and among charitable health care entities have also been questioned as to whether they violate fiduciary duties. Business conduct of some health care charities has been questioned as to whether it is somehow inconsistent with charitable status or violates a duty to charitable mission.

These "fiduciary duty" questions and conversion transactions require charities regulators to apply traditional charities law standards to fact situations that are arguably susceptible to varying interpretations and characterizations. Complexity and rapid change in the health care sector contribute to difficulty in discerning how charities law standards should be applied in particular cases. Some have argued that changes in public policy, government oversight and legal requirements in the health care arena should affect the interpretation of charities standards and analysis in health care.

In Massachusetts, the MAGO has traditionally played a role as "honest broker" of information and assessment of aspects of the health care market.[3] At the same time, the Office enforces consumer protection, antitrust and other legal standards in addition to charities law. Analyses of the same fact situation from these different legal perspectives can lead to differing conclusions. Health oversight agencies such as the Department of Public Health and the Division of Insurance bring their own standards and analyses to bear when their jurisdiction is implicated. Recent enactment of significant changes in our state health care system oversight structures,[4] coupled with federal health law and policy changes, create the potential for still other views from government regulators about the desirability, appropriateness and permissibility of certain health care transactions, business relationships and payment arrangements that may present questions under charities law.

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[2] A health care "for-profit conversion" is the sale of all or a substantial part of the assets of a charitable entity, typically a hospital, health maintenance organization or other health care provider, to a for-profit corporation, with a resulting change in purpose or dissolution of the seller charity. For the sake of simplicity, our discussion will focus on hospital conversions.

[3] For example, Massachusetts Attorney General Martha Coakley has, since assuming office in 2007, prioritized transparency of information on all public charities, and created a Health Care Division to focus even more specifically on this sector. In 2008, the legislature granted the MAGO special authority to examine why health care costs increase faster than general inflation. Since then, the office has produced reports on health care cost trends and drivers and continues to analyze and report on the health care system. *See, e.g.*, Office of Attorney General Martha Coakley, Examination of Health Care Cost Trends and Cost Drivers Pursuant to G.L. c. 118G, § 6½(b): Report for Annual Public Hearing , March 16, 2010, *available at* http://www.mass.gov/ago/docs/healthcare/final-report-w-cover-appendices-glossary.pdf, and Office of Attorney General Martha Coakley, Examination of Health Care Cost Trends and Cost Drivers Pursuant to G.L. c. 118G, § 6½(b): Report for Annual Public Hearing, June 22, 2011, *available at* http://www.mass.gov/ago/docs/healthcare/2011-hcctd-full.pdf. These developments built on previous legislative requests that the MAGO evaluate business practices of health care public charities for consistency with charitable status and exercise of fiduciary duties. *See* Attorney General Reilly's September 12, 2001 "Report to the Legislature on the Springfield Health Care Market" *available at* http://web.archive.org/web/20051224002108/http://www.ago.state.ma.us/filelibrary/Sphealth.pdf.

[4] An Act Improving the Quality of Health Care and Reducing Cost Through Increased Transparency, Efficiency and Innovation, Chapter 224 of the Acts of 2012, (hereafter "Chapter 224") referenced in Part III below.

Rapid change in the health care sector and in government's oversight, regulation and mode of participation in it may create opportunities to re-evaluate the role of charities law in health care. Does this environment call on charities regulators to incorporate new factors, such as public interest or consistency with health care public policy, into their analyses? Or, does it call on us to apply requirements, such as devotion of assets solely to charitable purpose, strictly and without regard to changes in the environment, lest the line between charitable mission and private gain become blurred in the health care context? From yet another perspective, does it create an opportunity to incorporate charities law standards into substantive health sector oversight and regulation, or opportunities for active collaboration between charities regulators and health care sector regulators? We examine these and related questions first through discussion of recent charitable hospital conversions, focusing on the application of *cy pres* doctrine and fiduciary duty analysis. Second, we discuss evaluation of compensation practices. Thereafter we discuss examples of fiduciary duty analysis in the context of business arrangements and practices. We offer no definitive conclusions, but hope to illuminate the questions through real and hypothetical examples and to provoke constructive dialog that can inform charities regulators confronting health care questions and cases in this environment of rapid change.

I. HOSPITAL CONVERSIONS

Charitable hospital representatives say that they feel pressure to explore conversion alongside other strategic options as a means of accessing necessary capital funding and as a means of establishing connections they perceive as necessary for survival in the changing health care marketplace.[5] With respect to capital funding, for example, some not-for-profit hospitals may believe that they will be unable to obtain from prospective not-for-profit partners the substantial resources necessary to implement electronic medical records and other information systems they believe they need in order to manage services for a defined patient population or for other public policy goals or requirements as contemplated by federal health care initiatives,[6] including the Patient Protection and Affordable Care Act (the "ACA").[7] Many charitable hospitals have experienced low or negative operating margins for years, causing them to defer ordinary capital expenditures for property and plant maintenance. Faced with the combination of accumulated "ordinary" capital needs and newer technology investments they believe are required, hospital representatives have said that the pressure to find a source for capital investment is now far greater than in the past and that this pressure exceeds ordinary business challenges such as delivering quality services efficiently at low cost.

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[5] *See, e.g.*, Robert Weisman, *Hospitals Strained in a Changing Landscape*, BOSTON GLOBE, September 8, 2012.

[6] Examples of federal health care programs and requirements cited as calling for significant new capital investment include the so-called "Meaningful Use" incentive program of the Centers for Medicare & Medicaid Services, implementing Title IV of Division B of the American Recovery and Reinvestment Act of 2009 (ARRA), Pub. L. No. 111-5 (2009) (encouraging adoption of electronic health records), and demonstration projects or initiatives authorized by the Affordable Care Act, Pub. L. No. 111-148 (2010) (e.g., Medicare Shared Savings program, Pioneer Accountable Care Organization program).

[7] Pub. L. No. 111-148 (2010).

A. The Attorney General's Role

When a charitable hospital proposes to sell its assets to a for-profit entity, the attorney general's jurisdiction to see to the due application of charitable assets is implicated. The attorney general may act under a specific state for-profit conversion statute or common law. In addition, the health department or other hospital licensing authority in a state may oversee the transfer of a hospital's operating license and may conduct public hearings in carrying out this function. While attorney general's office and health department staff may coordinate in reviewing proposed transactions, their roles and the standards they apply in review are separate and distinct. The attorney general's role derives from more general legal authority grounded in charities law, while the health department's role derives from authority specific to oversight of health care providers.[8]

B. Legal Standards and Principles: cy pres

Where attorneys general are called upon to consider modification of a charitable trust, they employ the *cy pres* doctrine. *Cy pres* means "as near as possible" and is the legal doctrine that requires charitable funds to be used according to the charitable purposes for which they are held, unless it is impossible, impracticable, or illegal to continue to do so. If it is impossible, impracticable, or illegal to carry out the original charitable purpose, court approval is usually required to change the way the funds are used, and the changed purposes must be as near to the original purposes as possible.

The law has been unsettled as to whether, and to what extent, the assets of charitable corporations are held in trust and thus whether *cy pres* and other charitable trust doctrines apply to charitable corporations. In *Attorney General v. Hahnemann Hospital,* the Massachusetts Supreme Judicial Court held that a charitable hospital corporation could broaden its purposes by amending its charter, but that the corporation could not use unrestricted funds received prior to the charter amendment for purposes added in the charter amendment.[9] *Hahnemann*, in effect, treated unrestricted assets of a charitable corporation as held in trust for the purposes stated in the charitable corporation's charter. A number of states have relied on *Hahnemann* to apply *cy pres* principles to conversions of health care charitable corporations.[10]

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[8] In *Attorney General v. Hahnemann Hospital*, 397 Mass. 820, 494 N.E.2d 1011 (1986), the court refuted Hahnemann's argument that its proposed sale of its assets was governed exclusively by health care statutes and that Attorney General had no authority, noting that there is no "overlap in the general regulatory authority of the Attorney General over charitable corporations and the specific authority of the Department of Public Health over health care." *Hahnemann*, 397 Mass. at 829, 494 N.E.2d at 1017 n.13.

[9] *Hahnemann*, *supra* note 8, 397 Mass. at 834-36, 494 N.E.2d at 1020–21.

[10] *See, e.g., Banner Health System v. Long*, 663 N.W.2d 242 (S.D. 2003) (general corporate assets subject to a hospital conversion might be subject to an implied charitable trust). Similarly, other courts have held that general corporate assets are held in trust for furthering charter purposes. *Queen of Angels Hosp. v. Younger*, 66 Cal. App. 3d 359, 365 (Cal. Ct. App. 1977) (hospital corporation could not abandon its primary purpose to establish free medical clinics); *Blocker v. State*, 718 S.W.2d 409, 415 (Tex. Ct. App. 1986) (unrestricted gifts were impressed with a charitable trust to be used consistent with the purposes declared in the corporate charter). *See also* Section 2(3) of the Uniform Prudent Management of Institutional Funds Act and associated comments (written documents used at the time of a gift, including solicitation materials or organizational documents, can be considered part of a gift instrument creating the terms of a gift) *available at* http://www.uniformlaws.org/shared/docs/prudent%20mgt%20of%20institutional%20funds/upmifa_final_06.pdf.

In July 1998, the National Association of Attorneys General ("NAAG") adopted a model "Nonprofit Healthcare Conversion" act (the "NAAG Model Act")[11] based on the experiences of the attorneys general in California, Ohio, Massachusetts and New Hampshire, who had applied the *cy pres* model to hospital conversions in their states.[12] Since then, conversion statutes have been enacted in 24 states,[13] many of them relying on a *cy pres* model based on the NAAG Model Act.[14] Under a *cy pres* analysis, a charitable hospital must carry on its operations in charitable form unless the hospital can demonstrate that continued operation is impossible, impracticable, or illegal without a sale of its assets.[15]

A *cy pres* analysis of the impracticability of a charitable hospital's survival examines not only the circumstances giving rise to the hospital's proposal to sell, but also whether there exist reasonably viable charitable alternatives to fulfill the hospital's purposes, including mergers and/or strategic alliances with other not-for-profit hospital systems and alternative transactions with for-profit or not-for-profit partners such as the disposition of a subset of assets, leases, or

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[11] NAAG Model Act for Nonprofit Healthcare Conversion Transactions, *available at* http://apps.americanbar.org/antitrust/at-committees/at-state/pdf/state-practices/at-healthc_conv_guidelines.pdf.

[12] *Accord*, MARION R. FREMONT-SMITH, GOVERNING NONPROFIT ORGANIZATIONS 440 (2004): "[T]he English rule that the assets of charitable corporations are subject to the doctrines of cy pres and deviation, regardless of their source, and regardless of whether they were given subject to explicit restrictions, is clearly preferable." Contrary to the English rule, however, the common law of some states without conversion statutes does not recognize the corporate *cy pres* doctrine. *See* draft ALI Principles of the Law of Nonprofit Organizations, which take the position that a charity can change the purpose to which unrestricted assets are devoted by amending its governing documents to change its corporate purpose, regardless of the extent of the change. PRINCIPLES OF THE LAW OF NONPROFIT ORGS. § 400, cmt. (d)(3) (American Law Institute, Preliminary Draft No. 5, 2009) (stating, "a facially unrestricted gift made to a charity having a single, narrow purpose is not viewed as a restricted gift. Rather, a donor's desire that the gift be used for a specific purpose must be expressed, in writing, in order for the recipient charity to be bound to use that gift for that purpose.").

[13] There are conversion statutes in Arizona, California, Colorado, Connecticut, the District of Columbia, Georgia, Hawaii, Idaho, Louisiana, Maryland, Massachusetts, Montana, Nebraska, New Hampshire, New Jersey, North Carolina, Ohio, Oregon, Rhode Island, South Dakota, Vermont, Virginia, Washington, and Wisconsin.

[14] Conversion statutes in the following states are patterned after the NAAG Model Act *cy pres* model, requiring that conversion proceeds are utilized for purposes consistent with the selling hospital's purposes: California, Colorado, Connecticut, the District of Columbia, Georgia, Hawaii, Idaho, Louisiana, Maryland, Massachusetts, Montana, Nebraska, New Hampshire, New Jersey, Ohio, Oregon, Rhode Island, South Dakota, Vermont, Washington, and Wisconsin. The Pennsylvania Attorney General also has posted a hospital conversion protocol on her web site which mirrors the NAAG Model Act cy pres model, *available at* http://www.attorneygeneral.gov/consumers.aspx?id=229. However, conversion statutes in Arizona, North Carolina, South Dakota, and Virginia do not follow the NAAG *cy pres* model. *See also* draft ALI Principles of the Law of Nonprofit Organizations, *supra* note 12, which take the position that a charity can change the purpose to which unrestricted assets are devoted by amending its governing documents to change its corporate purpose.

[15] A.W. SCOTT, SCOTT ON TRUSTS §§ 381, 399 (4th ed. 1987). Under the Massachusetts conversion statute, Mass. Gen. Laws ch. 180, § 8A(d), the MAGO reviews transactions involving the sale or transfer of non-profit hospital assets or operations to for-profit entities. Section 8A(d)(1) provides, in part: "A nonprofit acute-care hospital . . . shall give written notice of not less than 90 days to the attorney general . . . before it enters into a sale, lease, exchange, or other disposition of a substantial amount of its assets or operations with a person or entity other than a public charity. . . . When investigating the proposed transaction, the attorney general shall consider any factors that the attorney general deems relevant, including, but not limited to, whether: (i) the proposed transaction complies with applicable general nonprofit and charities law; (ii) due care was followed by the nonprofit entity; (iii) conflict of interest was avoided by the nonprofit entity at all phases of decision making; (iv) fair value will be received for the nonprofit assets; and (v) the proposed transaction is in the public interest."

joint ventures.[16] Assessment of whether any available not-for-profit alternatives are actually "viable," however, is not always straightforward. For example, the conversion applicant may assert that a potential not-for-profit bidder's proposal to acquire its assets is not viable because the bidder's financial condition is not robust enough to meet the capital needs of the resulting combined charitable entity. Evaluation of such an assertion may require regulators to assess whether projected capital needs are truly "necessary" for the post-transaction not-for-profit entity's survival. If the necessity of projected expenditures is tied to a particular view of how the health care market is likely to develop – in terms of competitive pressure or anticipated health care regulation – such as investment in information systems to manage population health, for example, charities regulators may be called upon to assess whether the applicant's view of future market demands is reasonable or not. This assessment may require input from health care market experts and health care policy experts.

If sale of the not-for-profit hospital is permissible because the hospital's continued operation is impossible or impracticable and there are no reasonably viable not-for-profit alternatives, the *cy pres* doctrine requires that any proceeds resulting from the for-profit conversion must be used for purposes as near as possible to the historical purposes of the converting hospital.[17] Sale proceeds could be used to meet unmet health needs of the same class of beneficiaries in the selling hospital's geographic region, such as screening, health promotion, providing access to care, subsidizing insurance premiums, or free care. Given the financial distress of many not-for-profit hospitals, however, the fair market value of the assets transferred is sometimes equal to the outstanding liabilities of the hospital, and accordingly there may be little or no sale proceeds left to allocate for charitable purposes.

C. Legal Standards and Principles: Duties of Care and Loyalty

An attorney general evaluating an application for conversion will also examine whether the selling hospital's board and managers have satisfied their fiduciary duties of care and loyalty in connection with a proposed conversion. The attorney general must ensure that the selling hospital board members have satisfied their duty of due care by determining whether: (i) the proposal is in the best interest of the not-for-profit hospital; (ii) fair value will be received for the hospital's assets; and (iii) the proposed transaction terms are fair and adequately protect the hospital's interest. While the standard to be met under the "due care" analysis is arguably less specific or stringent than the "impossible or impracticable" standard under a *cy pres* analysis, evaluation of the board's exercise of due care may involve assessment of the same kinds of assumptions about the future demands and requirements that the changing health care business and regulatory environment are placing on charitable hospitals.

An attorney general must also assess whether the selling hospital's board and managers fulfill their duty of loyalty, which requires them to keep the interest of the selling hospital above their own or any other interests. Thus, fiduciaries of the selling hospital must avoid conflicts of

[16] Some argue that application of the *cy pres* "impracticability" standard should be limited to the determination that the hospital cannot continue in its current not-for-profit form and that a lower "best interest of the hospital" standard should apply to the decision whether to sell all assets to a for-profit purchaser. More thorough application of the *cy pres* standard requires a determination that all not-for-profit proposals for sale or continuation of the hospital are "impracticable" before allowing a for-profit conversion.

[17] SCOTT, *supra* note 15, §§ 381, 399.

interest resulting from divided loyalties that could place them in a position to control or influence the selling hospital's decision-making process for their own personal benefit. This could occur, for example, if a bidder makes promises of future employment, consulting contracts, or other financial benefit to the selling hospital's board members or senior managers in return for their support for the prospective purchaser's bid. An attorney general's analysis of the proposed transaction includes careful examination of the hospital board's and senior managers' conflict of interest disclosure, assessment and management process during the consideration of conversion and alternatives. Potentially more challenging is assessment of the role of physician leaders and their interests in informing and influencing the board's assessment of a proposed conversion transaction and alternatives.

D. Emerging Standard: the Public's Interest

The NAAG Model Act[18] and the state conversion statutes it spawned have also expanded on the conversion analysis to add evaluation by the attorney general of whether the proposed transaction is in the public interest.[19] This has resulted in attorney general consideration of the impact the transaction may have on the hospital's traditional patient community (likely to be most directly affected) and on the health care system overall, including affordability and availability of services (especially for indigent patients or those with care needs that are historically under-reimbursed such as behavioral health services).

The addition of this "public interest" analysis expands an attorney general's role in conversion oversight from one based purely on charities (and charitable trust) law to one that includes a broader set of considerations. This development could be seen as an indication that charities law, or at least application of charitable trust principles, may not be sufficient to fully analyze a proposed health care conversion transaction, without specifically directing how the public's interest should be assessed or weighed in the analysis.

Attorneys general reviewing proposed hospital conversions under a statute that included this "public interest" aspect have sometimes conditioned their approval of the transactions on enforceable purchase contracts that require the purchasing for-profit hospital system to affirmatively address health care issues (for example, requiring maintenance of charity care commitments and of certain critical access services for a period of time after the acquisition).[20] Attorneys general have also sometimes required the insertion of contract provisions allowing the selling hospital or the community to buy back the hospital under certain circumstances as

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18 Section 5.02 of the NAAG Model Act, *supra* note 11, is an optional provision for "Attorneys General who deem it appropriate to also consider issues of health impact," including availability, accessibility or cost of health care. Conversion statutes in the following states have included evaluation of health impact in addition to a *cy pres* analysis: California, Colorado, Connecticut, the District of Columbia, Georgia, Hawaii, Louisiana, Maryland, Massachusetts, Montana, Nebraska, New Hampshire, New Jersey, Oregon, Rhode Island, South Dakota, Vermont, Washington, and Wisconsin. The Pennsylvania Attorney General's hospital conversion protocol also includes evaluation of public health impact as well as a *cy pres* analysis; *available at* http://www.attorneygeneral.gov/consumers.aspx?id=229.
Conversion statutes enacted by Arizona, North Carolina, and Virginia evaluate issues of health impact but do not require a *cy pres* analysis.

19 For example, see Mass. Gen. Laws ch. 180, § 8A(d), *supra* note 15.

20 *See, e.g.*, Office of Attorney General Martha Coakley, Statement of the Attorney General as to the Caritas Christi Transaction at 3-4 (2010) *available at* http://www.mass.gov/ago/docs/nonprofit/caritas/statement-of-the-attorney-general-caritas-christi-transaction.pdf.

well as "anti-flip" provisions providing that the selling hospital or community will share in any profit above the original purchase price if the for-profit buyer resells the hospital in a short period of time.[21] Finally, as some statutes expressly require, attorneys general can support transparency and public input into the process by, for example, posting transaction documents on the attorney general's website and hosting public hearings to obtain input about particular concerns the community may have about the transaction (which the attorney general may then attempt to address in requiring specific terms in the transaction documents).[22]

E. Emerging Issues

Assessing whether it is truly "impossible or impracticable" for a charitable hospital to continue operating in charitable form may be challenging if the applicant presents with a robust bottom line but claims "impracticability" based on changes in the market or perceived demands that are about to develop. A hospital board may believe that if it does not seek acquisition or some other form of "tight" affiliation with a larger health system, it is unlikely to survive emerging "bundled payment" systems or will be unable to manage health services for a defined population (and that it will be called upon to do so, in collaboration with physicians). The board may even determine that exercise of due care *requires* it to respond to changes in the health care environment by identifying and evaluating affiliation or acquisition models, even if it is not in immediate financial distress. Once the board's discussions move from an assessment of the health care environment to an assessment of its affiliation options, there may be momentum leading the board to determine that some form of affiliation is inevitable. Once that threshold is crossed, the board may engage in a comparison of options to determine which one looks "best" only to find that a for-profit suitor's proposal looks most appealing.[23] At what point along this slippery slope should a true assessment of impossibility or impracticability by the board occur?

As charities regulators, how much deference should we give to a board's determination in these circumstances that it is truly impossible or impracticable to continue operating the charitable hospital "as is"? Should we require that the board consider forms of affiliation that stop short of an asset sale? As a general rule, affiliations of any form between charities with the same mission do not come before charities regulators for the type of review conducted in conversion transactions. If the hypothetical board described above chooses a not-for-profit

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[21] *See* Section 12.2.4 of October 31, 2002 Asset Purchase Agreement between Nashoba Community Hospital Corporation and Essent Health Care-Ayer, Inc. providing for a Nashoba option to repurchase, *available at* http://web.archive.org/web/20051224011609/http://www.ago.state.ma.us/filelibrary/nashobaapa.pdf, along with the attached parties' agreed-to Form of Option to Repurchase Agreement, *available at* http://web.archive.org/web/20051224002108/http://www.ago.state.ma.us/filelibrary/Sphealth.pdf.

[22] *See, e.g.*, Mass. Gen. Laws ch. 180, § 8A(d)(2) and (3) (requiring MAGO to make available to the public all documents filed by parties to a proposed conversion transaction and to hold a public hearing in a location convenient to the population served by the selling charity).

[23] *See, e.g.*, Robert Weisman, *Beth Israel Plans to Acquire Jordan Hospital in Plymouth*, BOSTON GLOBE, January 24, 2013 (quoting Jordan Hospital president Peter Holden, "'We just said we're not big enough to be able to take the health care of the population and be at risk for it and have the resources to get there with the transformation of health care. . . . We wanted to make sure there was a vibrant health care system in Plymouth for generations to come,'" and noting that "teaming up with a nonprofit hospital system 'was not a requirement but it was a definite plus'").

partner, it will not be called upon to articulate the basis of its decision to affiliate. There is no application of an "impossible or impracticable" standard.

How should charities regulators assess the determination by a conversion applicant's board that available not-for-profit options were "not viable"?[24] What if the board determines that a for-profit partner will provide better access to capital, better payer contracts, and better clinical integration than any of the available not-for-profit options? May it select the for-profit "conversion" option because it believes it is in the "best interest" of the hospital? Charities law would say, generally, no. Must it first show some reason why each of the not-for-profit options is not likely to preserve the hospital's health care mission? Charities law would say, generally, yes.

In the case of Morton Hospital in Massachusetts, for example, the board determined for various specific reasons that the mission it was required to protect was maintenance of a full-service hospital in its community.[25] It had no charitable prospective partner or purchaser that would preserve that mission, and therefore proceeded with sale to a for-profit hospital operator. It is possible, however, that there might have been charitable partners willing to enter into a sale or affiliation that would have retained the hospital's charitable nature, but would have diminished the clinical services provided in its facilities and therefore in its community. Might the board have determined that the latter option was viable? Perhaps, but it did not do so. In the Morton Hospital case, we determined not to second-guess the board's reasonable construal of its mission, based on the particular facts in that situation. But a different board might have reached a different conclusion about the competing priorities of holding charitable assets charitable, and serving the health care needs of the community in the way most closely aligned with its historic mission. How far should charities regulators push to maintain charitable status, even where fundamental change in the nature of services available at the resulting charitable hospital will result?

Sometimes assessment of "viability" of other options turns on application of other legal standards. To what extent should charities regulators defer to a board's assessment that other legal requirements render a not-for-profit option "non-viable"? For example, if a board determines, on its own, that acquisition by the only charitable bidder would likely have run afoul of antitrust law or would have led to organizational "culture clash," should charities officials defer to that determination and conclude that the charitable bid was not viable?

As our state and national governments struggle to control health care cost increases, provide broad access to high-quality care, and experiment with new ways of financing, organizing and overseeing the health care system, where should the charitable *cy pres* standard for preserving charitable assets fall in the hierarchy of policy goals? As government plays a larger role in health care financing through Medicare, Medicaid, government employee health

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[24] For example, see discussion of viability of not-for-profit options in the Morton Hospital transaction in Massachusetts. Office of Attorney General Martha Coakley, Statement of the Attorney General as to the Morton Hospital Transaction at 9 and 25 (2011) (hereafter, the Morton Statement), *available at* http://www.mass.gov/ago/docs/nonprofit/morton/morton-ag-statement.pdf.

[25] *See* the Morton Statement, *supra* note 24, at 9 and 21 (finding that it was not unreasonable for the Morton Hospital board to find that continuation of its mission required maintenance of a full-service hospital in its community, because it determined that residents of its service area would be unlikely to travel to receive services at potential not-for-profit partner service sites and would more likely travel further to higher-cost Boston hospitals).

benefit programs, tax expenditures and subsidies, as well as in regulation and oversight, is there some point at which the charitable "health care" mission should be broadened to include "relieving the burdens of government," or would that risk diluting the health care mission? If we begin to view those purposes as aligned, can we say that they have become joined by virtue of changes in the health care environment, or is court approval required?[26] Is there the potential for tension between the charities law perspective that charitable assets should remain held in trust, and a health care regulatory perspective that, as long as health care sector participants comply with comprehensive health care regulation aimed at controlling costs, providing access and ensuring quality, then they are relieving the burdens of government and acting in the public interest, and for-profit vs. charitable status is less important? Alternatively, does the rise of health care sector regulation that applies to for-profit and charitable participants alike make it even more important for charities regulators to hold fast to strict interpretation of charitable mission, in order to avoid dissipation of charitable assets into private interests through conversions or other transactions approved under a general health care oversight regime?

II. COMPENSATION PRACTICES

Generous compensation practices among public charities have raised questions about whether charitable funds are being appropriately applied and about whether duties of care or loyalty have been violated in the construction of arrangements leading to high levels of compensation. Concerns have been raised about whether the process outlined in IRC § 4958 and related regulations has led to or at least supported an acceleration of the rate of increase in executive compensation among public charities. [27]

In the health care arena, for-profit and charitable entities sometimes provide similar services and conduct similar activities "side by side." As a general matter, members of the public and the press may expect that salaries will be higher in for-profit enterprises than in public charities. Where they are in direct competition with for-profits, charities representatives have said that they feel compelled to increase compensation in order to avoid losing top talent – executives or physicians – to more generous compensation offers from for-profit competitors.

To avoid charges of private inurement and "excess benefit transactions," charitable health care entities must refrain from paying more than "fair market value" for services. However, if a for-profit competitor of a charitable hospital, for example, – not bound by the

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[26] In *Harvard Community Health Plan v. Board of Assessors of Cambridge*, the court acknowledged that "[M]ajor changes in the area of health care, especially in modes of operation and financing, have necessitated changes as well in definitional predicates. The term 'charitable,' as applied to health care facilities, has been broadened since earlier times, when it was limited mainly to almshouses for the poor. As a result, the promotion of health, whether through the provision of health care or through medical education and research, is today generally seen as a charitable purpose. . . . Such a purpose is separate and distinct from the relief of poverty, and no health organization need engage in 'almsgiving' in order to qualify for exemption." *Harvard Community Health Plan, Inc. v. Board of Assessors of Cambridge*, 384 Mass. 536, 542-543, 427 N.E.2d 1159, 1163 (1981) (internal citations omitted).

[27] *See, e.g.*, Examination of Executive and Director Compensation: Increased Oversight, memorandum from David Spackman, Chief, Non-Profit Organizations/Public Charities Division, Office of Attorney General Martha Coakley, September 2, 2009, *available at* http://www.mass.gov/ago/docs/nonprofit/bcbs-memo-090209.pdf.

same "fair market value" legal requirement – offers key physicians considerably more in compensation in hopes of wooing them away, is the hospital justified in matching the offer even if it exceeds what market studies would generally support? What defines "market value" more precisely than a competing offer, they might argue?

On the other hand, matching a high offer from a competitor for physician services could lead to unsustainable system costs – both for the charitable hospital itself and ultimately for the health care system as a whole. Charity board members in this circumstance clearly would need to use due care to weigh the risk of over-committing to physicians at the expense of other aspects of operations, against the risk of losing key physician talent, leadership and clinical capacity. From a broader perspective, do charity board members also owe a fiduciary duty to avoid matching higher compensation offers where it is not clear that competition in the market is functioning to restrain costs? Do board members of charitable hospitals owe a duty of some kind to the larger mission of health care – for example, to avoid taking actions that might contribute to cost increases without a discernible increase in quality or access – that is not owed by boards of for-profit hospitals or health systems?

III. FIDUCIARY DUTIES

In addition to examining fiduciary duties in the context of conversions and compensation decisions, attorneys general have been called upon to examine whether certain aspects of market conduct are consistent with fiduciary duties. Often this involves examining the extent to which collaboration, activities and expenditures further the charitable purpose or mission of the organization.

In *Lifespan Corporation v. New England Medical Center, Inc.*,[28] the MAGO intervened in a case in which New England Medical Center (NEMC, now called Tufts Medical Center) alleged that its one-time corporate parent, the Rhode Island-based Lifespan, had breached fiduciary duties it owed to NEMC by virtue of the control it exercised over NEMC as its sole corporate member. The court held that Lifespan did owe a fiduciary duty to NEMC[29] and that it had breached that duty by, among other things, failing to ensure that payer rates would increase at a reasonable level in comparison to other members of the Lifespan system.[30]

The Lifespan decision has raised questions about whether board members of corporate parents generally owe fiduciary duties to subsidiaries, and about how to evaluate the interests and missions of subsidiary entities in larger corporate families, as distinct from the interests and missions of the system as a whole.

As health care entities form new affiliations for purposes of clinical care or financial risk-sharing, similar questions of fiduciary duty may arise. Particularly where charities and for-profits join together in an affiliation or joint venture,[31] the differentiation of duties and mission of the constituent entities as distinct from the collaborative enterprise may be

[28] 731 F.Supp.2d 232 (D.R.I. 2010).
[29] *Id.*, 731 F.Supp.2d at 238-241.
[30] *Lifespan Corporation v. New England Medical Center, Inc.,* 2011 WL 2134286, **16 (D.R.I. May 24, 2011).
[31] We use the term "joint venture" in this discussion to refer generally to any form of collaboration between hospitals and other health care entities involving sharing of revenue, risk, and/or patient care.

challenging. For example, if a charitable hospital joins with for-profit physician groups to share patient care revenues, is it justifiable for hospital representatives on the board of the joint venture to support payment of subsidies to the physician groups in order to support higher salaries for the physicians, even if it means a reduction in the amount paid to the hospital? Could hospital leaders reasonably conclude that such revenue sharing actually furthers the hospital's mission because it will result in or increase physician engagement in appropriate care management under the joint venture's clinical guidelines, which in turn will support the system and the hospital?[32]

Put another way, as health care re-organizes under different affiliation and payment models, it may become difficult to differentiate between the mission of the hospital and the missions of other related parts of a larger entity or organization. IRS guidance on joint ventures involving tax-exempt and non-exempt partners suggests that the exempt entity must ensure that its charitable resources are used exclusively in furtherance of its charitable mission, and that the charity must retain governance rights in the joint venture that allow it to ensure that this restriction on the use of its assets is maintained.[33] But where hospital leaders believe that health care public policy seeks to combine hospital and physician efforts and interests, it may be difficult to determine where the hospital's mission ends in the joint venture's set of activities. As boards struggle with these new models and with positioning their charitable hospitals for survival, they must work to support the success of their collaborations as well as their hospitals. Do fiduciary duties of care and loyalty permit consideration of the whole enterprise as well as the charity member?[34]

In the context of payment reform, some believe that health care organizations are expected to share financial risk for services, including services they do not directly provide. In Massachusetts, new legislation requires that before a health care provider enters into an alternative payment arrangement in which payments may exceed the cost of care, the provider must submit detailed financial information to the Division of Insurance and demonstrate that it can maintain solvency in light of the risk it proposes to assume.[35] Could a charitable hospital point to its board-restricted endowment – accumulated contributions for general hospital purposes, not more narrowly-restricted gifts – as financial resources available to support entering into risk-bearing arrangements with other types of providers and with insurers? We have seen that under Massachusetts law, while a hospital may add purposes to its charter, it may not expend assets donated for its original purposes for dissimilar purposes added later.[36] In this

[32] A recent IRS Private Letter Ruling found that the provision of data reports by an exempt entity operating a regional health information exchange for use in a physician incentive compensation program was consistent with exempt purposes because incentive compensation program was designed to further government health care policy and thus lessen the burdens of government and any private benefit resulting to the physicians was insubstantial. The discussion implicitly recognizes that incentive compensation of physicians is not inconsistent with charitable purposes, in light of larger health policy goals such as ensuring quality of care. Priv. Ltr. Rul. 201250025 (December 14, 2012), *available at* http://www.irs.gov/pub/irs-wd/1250025.pdf.

[33] *See* Rev. Rul. 2004-51, 2004-1 C.B. 974.

[34] The American Hospital Association has asked the IRS to reconsider restrictions on the private business use of space in facilities financed by tax-exempt bonds. In the context of ACOs, the AHA argues, exempt purposes and private business purposes of ACO partners are one and the same. *See* AHA Letter to Tim Jones, Branch V Chief Counsel, Financial Institutions and Products, Internal Revenue Service dated November 15, 2012, *available at* http://www.aha.org/letters/2012?p=2.

[35] Chapter 224, *supra* note 4, §15.

[36] *Hahnemann*, *supra* notes 8 and 9.

context, though, hospital leaders may argue that public policy and the marketplace have required that hospitals include risk-sharing and relationships with other provider types as part of their purpose. Is this kind of externally imposed modification of mission so dissimilar as to require the same restrictions on gifts donated prior to the change? How much flexibility do hospital boards have in interpreting their missions broadly? Some states have recognized a duty of obedience to mission or corporate purpose that suggests limitations may be stricter in some states than in others.[37]

IV. CHANGING NATURE OF HEALTH CARE OVERSIGHT

Change in health care and in the definitional predicate associated with charitable health care missions is not new. But the role of government in health care financing and system oversight is taking on increased prevalence. Massachusetts' new "cost containment law" sets statewide targets for health spending growth that are tied to the expected rate of economic growth in the state.[38] It creates new oversight bodies with authority to intervene in the health care market if the system-wide target cost trend is not being met. Is it reasonable to foresee a point at which the charitable purpose of "health care" will be so closely aligned with the purpose of "relieving the burdens of government" that actions consistent with health care public policy goals should be deemed consistent with traditional charitable health care purposes?

If public policy encourages new forms of joint venturing in health care, should existing guidelines governing charitable and non-charitable joint ventures – such as the requirement that charitable entities retain governance rights sufficient to protect application of their charitable resources, which may conflict with other sources of governance requirements – be viewed more flexibly, as long as the joint venture as a whole operates in furtherance of health policy goals and is subject to health system regulator oversight? Or can existing guidelines adequately protect the charity?

If the goal of restricting health care cost increases is to succeed, will opportunities for private inurement and operation for private benefit be curtailed, regardless of ownership structure? Is it possible that at some point, comprehensive health care system oversight will effectively require the system to operate for the public good rather than for private benefit? Or, will other changes in the health care arena result in more effective competition in the market, thereby restraining costs irrespective of ownership model?

At this time, of course, it is too soon to say whether comprehensive health care regulation will ever subsume or directly incorporate principles of charities law. For now, charities regulators need to remain vigilant in enforcing restrictions on charitable assets in health care. Assets devoted to non-revenue-producing efforts such as research, teaching, and development of treatment for rare or so-called "orphan" conditions need to be safeguarded and

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[37] *See, e.g.*, *Manhattan Eye, Ear & Throat Hospital v. Spitzer*, 186 Misc.2d 126, 715 N.Y.S.2d 575 (December 3, 1999) (recognizing that the board of directors of a charitable corporation is charged with the duty of obedience to mission or corporation purposes and thus to ensure that the mission of the charitable corporation is carried out).

[38] Mechanic, Altman & McDonough, *The New Era of Payment Reform, Spending Targets, and Cost Containment in Massachusetts: Early Lessons for the Nation*, www.HealthAffairs.org, October 2012 *available at* http://healthforum.brandeis.edu/publications/pdf/Mechanic.Altman.Oct.2012.HIF.Site.Version.pdf.

applied to those purposes. Otherwise, they may be redirected to more generic health care operations in an effort to control costs of general health care services. Over time, the health care regulatory structure may encompass some of these activities as well. For example, as research that translates findings from basic science to practical applications brings innovative and expensive diagnostic and treatment technology to the bedside, traditional health insurance is unlikely to cover the costs for any individual patient. Yet society as a whole will benefit from supporting these efforts.

Charities regulators need to continue to guard against conversion of charitable health care assets to private gain; to ensure that restricted assets (*i.e.*, those given for a purpose narrower than the recipient's general purposes) are protected; and to guard against breaches in the duty of loyalty through conflicts of interest. Attorneys general should continue supporting the goals of transparency and preservation of the public's interest in health care charitable assets and operations, which appears to be consistent with the goals of health care regulatory bodies. We see the need for health care expertise and input in application of charities law standards in the health care arena, and also the potential for aspects of charities regulation and enforcement in the health care arena to be exercised in collaboration with health care regulatory bodies. While health care related charitable purposes can and should be reconciled with the public's interest and the common good arising from the health care system as a whole, charities law standards and the authority underlying them remain distinct, and we stop short of predicting that substantive health care regulation will subsume charities law in health care.