2003 HEALTH LAW UPDATE

Presented by
HONIGMAN MILLER SCHWARTZ AND COHN LLP

May 20, 2003
8:30 AM
The Hotel Baronette
Novi, Michigan

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2003 HEALTH LAW UPDATE
Tuesday, May 20, 2003
The Hotel Baronette – Novi, Michigan

Schedule

8:30 a.m. **Registration and Continental Breakfast**

9:00 a.m. **Gerald Griffith – Welcome**

9:05 – 10:30 a.m.

I. ***Medicare Audits***

II. ***Current Developments With Captive Insurance and Alternative Finance Practices***

III. ***Recent CON Developments***

- Public Act 610 of 2003
- Pilot project for high-occupancy hospitals
- Possible changes to standards for Hospital Beds, CT Scanners and Cardiac Catherization Services

IV. ***Recent Developments in Business Immigration Law***

- New Department of Homeland Security and the dissolution of the INS
- Special Registration for certain male nonimmigrants
- Department of State security checks and visa delays
- Recent developments in immigration for health care professionals

10:30 – 10:45 **Break**

10:45 – 12:15

V. ***Joint Venture Developments***

- Impact of the *Indenbaum* legislation on Michigan joint ventures
- Recent OIG advisory opinions and more options for ASCs
- St. David's case and the IRS view of nonprofit/for-profit joint ventures
- State nonprofit and charitable trust law trends

VI. ***Medicaid Program Changes & Update on Blue Cross Appeals Issues and Potential Medicare Appeals Issues***

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10:45 – 12:15 continued	**VII.**	***Potential Antikickback Implications of Hospital Credentialing Policies***

- Overview of the Potential Antikickback Implications of Hospital Credentialing Policies
- The Possible Parameters of a Future OIG Safe Harbor on Credentialing
- Mandating Referrals As A Condition of Maintaining Privileges - Antikickback Statute and Stark Law Considerations

VIII. ***Sarbanes-Oxley***

- History of new focus on Corporate Accountability
- Regulatory and other Responses to Enron (public and nonprofit requirements)
- Implementation Strategies for Heightened Accountability

12:15 – 12:30 **Questions and Answers**

12:30 – 1:30 **Lunch**

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Medicare Validation Surveys

A. Why do Surveys Occur

1. Every Hospital that participates in Medicare is obligated by its Medicare provider agreement to comply with the Medicare Conditions of Participation (COP).

2. Most hospitals have "deemed status" by virtue of being accredited by JCAHO, meaning that they are deemed to meet the COP because they are accredited by JCAHO.

3. CMS is not precluded from surveying hospitals with deemed status to determine if they comply with the COP.

4. These surveys, called validation surveys, are usually triggered in one of two ways. A certain number of surveys are conducted as "representative samples" to determine if the accrediting body requirements are "at least as stringent as those established by HCFA [CMS], taken as a whole." These are random surveys. Random surveys are increasing as a result of the increasing criticism by the government of the standards of JCAHO.

5. Surveys also can be triggered as a result of a complaint to CMS from the public, which occurs most often when a patient or patient's family, a disgruntled employee, or a physician or other interested person files a complaint either with the state or CMS. Other ways in which a survey can occur is where there is an incident or a particularly bad outcome that is publicized.

6. Surveys have been triggered by inattention to patient rights, complaints relating to shortage of nurses, poor discharge planning and egregious errors.

7. Because of the increased number of validation surveys being conducted, hospitals should implement a plan of review to assure favorable results if a survey is conducted. At a minimum, hospital administration should review the Medicare survey forms and identify any areas of hospital operation requiring attention prior to a survey being scheduled.

B. Survey Process

1. A facility may not legally refuse authorized officials from making unannounced visits. Refusal to allow the visit may result in Medicare termination.

2. Upon arrival at the hospital, surveyors usually meet with the administrator or other appropriate hospital staff to outline how the survey will be conducted. The surveyors need to verify all facts by interviewing source documents and by interviewing staff. Thus, individual staff members may be asked how they would handle an emergency, such as a fire or code blue.

3. Surveyors may allow or refuse to allow facility staff to accompany them during the survey.

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4. Surveyors also may request documentation of quality assurance activities, and evidence that identified quality problems have been addressed and corrected by appropriate follow-up.

C. Exit Conference

1. At the conclusion of the survey, an exit conference will be held to communicate informally preliminary findings.

2. An attorney may be present at the exist conference, but the surveyors can terminate the conference if it looks like it is being turned into an evidentiary hearing.

3. You can record the exit conference if a copy of the tape is given to the surveyors. The surveyors can determine if the exit conference may be videotaped.

4. Every effort should be made to deliver necessary documentation BEFORE the surveyors leave the hospital.

5. If the submission of documentation is permitted after the exit conference, the hospital should verify that it has a complete list of requested documentation and the outside date for its submission.

D. Plan of Correction

1. Before receipt of written survey findings, begin to develop a plan of correction, as the time frame for submitting plans of correction is very short.

2. Upon receipt of the written findings, the hospital can accept the deficiencies and file a plan of correction, record objections to the cited deficiencies and submit a plan of correction, or record objections to the cited deficiencies and provide convincing arguments and documented evidence that the deficiencies are invalid. The latter course is not recommended.

3. A "credible allegation of compliance" and a plan of correction must be submitted within ten days. The credible allegation of compliance is a letter stating the situation has been corrected, and the hospital is now in compliance and this is the plan of correction.

4. The Plan of Correction must be specific and realistic, stating exactly how the deficiency was or will be corrected and the specific time frame for completion of the action. The plan of correction must identify who is responsible for taking the corrective action, when the corrective action will be completed and how on-going compliance will be monitored.

5. An unacceptable plan of correction can result in sanctions, including notice of termination from the Medicare program.

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6. While an appeal can be taken from a decision to terminate, the appeal does not stay the termination, and no provider can afford termination from the Medicare program while pursuing the appeal.

E. Other Related Items of Note

1. CMS has proposed an amendment to the fire safety standards to adopt the 2000 edition of the Life Safety Code (issued by the National Fire Protection Association) and to eliminate references to earlier editions. This means that much stricter standards are apt to apply if this proposal is adopted.

2. CMS issued a final rule requiring hospitals to develop and maintain a quality assessment and performance improvement program (QAPI).

F. QAPI

1. A QAPI is not designed to measure a hospital's quality, but rather is a minimum requirement that the hospital systematically examine its quality and implement specific improvement projects on an ongoing basis.

2. The governing body must ensure that the program reflects the complexity of the hospital's organization and services, involves all hospital departments and services (including those furnished under contract or arrangement) and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors.

3. The program must be ongoing and show measurable improvement in indicators for which there is evidence that it will improve health outcomes and identify and reduce medical errors.

4. The hospital must measure, analyze and track quality indicators, including adverse patient events, and other aspects of performance that assess processes of care, hospital service and operations.

5. There also are standards relating to program indicator data, performance improvement activities, and performance improvement projects.

6. The focus of the QAPI is to identify and verify quality-related problems and their underlying cause, design and implement corrective action activities to address deficiencies, and follow-up to determine the degree of success of an intervention and to detect new problems and opportunities for improvement.

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CURRENT DEVELOPMENTS WITH CAPTIVE INSURANCE AND ALTERNATIVE FINANCE PRACTICES

I. Increasing Costs

A. Increased cost of risk transfer, despite Michigan loss trends

(i) impact of national loss trends

(ii) insurer concern regarding continued benefit from Michigan tort reform legislation

(iii) commercial insurers dealing with losses across many lines of coverage (disasters and past underpricing)

(iv) commercial insurers experiencing poor investment results

B. Increased opportunities for cost savings and program enhancements from alternative risk financing arrangements

(i) physician programs sponsored by health systems

(ii) retaining greater risk

(iii) emphasis on medical error reduction and quality improvement

II. Jenkins Decision

A. Decided by Michigan Court of Appeals in April 2003

B. Medical malpractice cap on non-economic damages inapplicable to death caused by medical malpractice

C. Impact on settlement position of plaintiff's attorneys

III. OIG Guidance Letter

A. Addresses malpractice subsidies for physicians

B. Acknowledgment of malpractice crisis (Michigan not included)

C. Impact difficult to predict

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IV. Proposed Federal Tort Reform--The HEALTH Act

A. Highlights

(i) statute of limitations

(ii) payments proportionate to fault

(iii) structured awards

(iv) cap on non-economic damages

(v) limited punitive damages

(vi) limits on attorney contingent fees

B. Limited preemption of state law

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2003 HEALTH LAW UPDATE

RECENT CON DEVELOPMENTS

MAY 20, 2003

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I. PUBLIC ACT 619 OF 2002

On December 31, 2002, Governor John Engler signed into law Public Act 619 which made significant revisions to Michigan's Certificate of Need law, Part 222 of the Public Health Code. The Act took effect on March 31, 2003. A discussion of key components of the Act is set forth below.

A. Changes to Capital Expenditure Thresholds

The capital expenditure threshold for the acquisition, improvement, expansion, addition, conversion, modernization, new construction or replacement of a clinical service area was increased from $2,000,000 to $2,500,000, as adjusted annually. The capital expenditure threshold for a non-clinical service area was eliminated (*i.e.*, non-clinical capital expenditures are no longer subject to CON regulation). **See MCL 333.22203(9).**

B. Composition of CON Commission

The Act expanded the five-member CON Commission to 11 members appointed by the Governor with the advice and consent of the Senate. Representation on the CON Commission will include two individuals representing hospitals, an allopathic physician, an osteopathic physician, a physician representing medical education, an individual representing nursing homes, a nurse, an individual representing a self-insured company, an individual representing a non-self insured company, a representative of Blue Cross and Blue Shield of Michigan, and an individual representing organized labor unions. **See MCL 333.22211.**

C. Relocation of Licensed Hospital Beds Without a CON

<u>The Act may allow the relocation of licensed hospital beds without a CON under the following circumstances:</u>

1. From a licensed hospital site to another hospital site licensed under the same license as the transferring hospital if both hospitals are located within a 2-mile radius of each other. **See MCL 333.22209(3)(a).**

2. From a licensed hospital to a licensed freestanding surgical outpatient facility ("FSOF") if the FSOF satisfies each of the following criteria on Dec. 2, 2002: (i) **is owned by, is under common control of, or has as a common parent** the hospital seeking to relocate its licensed beds; (ii) was licensed prior to Jan. 1, 2002; (iii) provides 24-hour emergency care services at that site; and (iv) provides at least four different covered clinical services at that site. **See MCL 333.22209(3)(b).**

3. From a licensed hospital to another licensed hospital within the same health service area if the receiving hospital **is owned by, is under common control of, or has as a common parent** the hospital seeking to relocate its licensed beds. **See MCL 333.22209(3)(c).**

<u>The relocation of hospital beds described above are subject to some restrictions:</u>

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1. If the licensed hospital seeking to relocate its beds to an FSOF or to another licensed hospital within the same health service area is located in a city that has a population of 750,000 or more, then it is limited to a one-time transfer of no more than 35 percent of its licensed beds. **See MCL 333.22209(7).**

2. For the transfer of hospital beds to an FSOF pursuant to MCL 333.22209(3)(b), one of every two beds, up to a maximum of 100, must be beds that were staffed and available for patient care as of Dec. 2, 2002 and the transferring hospital may not reactivate licensed beds that were unstaffed or unavailable for patient care for a period of five years after the date of the relocation. **See MCL 333.22209(8).**

3. The above-described hospital bed relocation provisions in MCL 333.22209 are subject to the review of the new CON Commission. The CON Commission has until June 15, 2003 to make a determination as to whether the relocation of licensed hospital beds may cause great harm and detriment to the access and delivery of health care to the public; upon such a determination by the CON Commission, any relocation of hospital beds would require a CON under the current relocation standards. **See MCL 333.22209(9).**

Issues not addressed by MCL 333.22209:

1. Will an FSOF that receives hospital beds under MCL 333.22209(b) be subject to licensure as a hospital?

2. The common ownership language that is used in MCL 333.22209(b) and (c) (*i.e.*, the hospital receiving the licensed beds is owned by, is under common control of, or has as a common parent the hospital seeking to relocate its licensed beds) is awkwardly drafted and ambiguous. Based on discussions with the MDCH, there is uncertainty as to whether the statute is intended to apply to transfers from Hospital A to Hospital B when both hospitals are owned by Holding Company P.

3. A internal MDCH memorandum dated December 17, 2002 indicates that the MDCH believes the provisions of MCL 333.22209(b) and (c) are applicable only if the transferring hospital is located in a city with a population of greater than 750,000 (*i.e.*, Detroit).

4. The Office of the Michigan Attorney General recently provided the MDCH with its analysis of Public Act 619 and it is our understanding that the analysis specifically addressed the issues noted in items 1,2 and 3 above. The analysis is being treated by the MDCH as privileged legal advice and has not been made publicly available.

D. CON Exemption for Certain MRI Units in Certain Counties

MCL 333.22224a provides that a person may initiate, expand, replace, relocate or acquire a fixed or mobile magnetic resonance imaging (MRI) service without obtaining a CON if the MRI unit will be located in a county that has a population of more than 160,000 person and does not have at least two existing MRI units. The person seeking to provide MRI services pursuant to this

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section must (i) be a nonprofit organization; (ii) demonstrate that the MRI services shall be accessible to all patients regardless of their ability to pay; and (iii) participate in the Medicaid program. Moreover, the person seeking to provide MRI services pursuant to this section must first file a letter of intent with the MDCH and receive its written acknowledgment of approval.

According to a special notice posted on the MDCH website, the MDCH has determined that only St. Clair County meets the criteria set forth under this section. Consequent to this determination, a person seeking to initiate, expand, replace, relocate, or acquire a fixed or mobile magnetic resonance imager (MRI) service within St. Clair County must file a completed Letter of Intent (LOI) with the MDCH and must also demonstrate its nonprofit status in the completed LOI and that the MRI service shall be accessible to all patients regardless of his or her ability to pay and shall participate in the Medicaid program.

The MDCH will verify eligibility and notify applicant(s) within 30 days after receiving their LOI. The MDCH will group all eligible LOIs received during each business day for review. The MDCH will send a written acknowledgment to the eligible applicant(s) approving the initiation, expansion, replacement, relocation, or acquisition of a fixed or mobile MRI unit. LOIs received and determined to require a Certificate of Need will be notified accordingly.

E. Medicaid Participation

The CON Commission is required to revise all CON review standards (with the exception of the nursing home and long-term care unit bed review standards) to include a requirement that each CON applicant participate in the Medicaid program by January 1, 2004. **See MCL 333.22215(b).** (How will this apply to an FSOF that is not reimbursed by Medicaid?)

II. PROPOSED CON REVIEW STANDARDS FOR HOSPITAL BEDS

On April 24, 2003 the MDCH held a public hearing on proposed CON review standards for hospital beds. The key modification to the existing standards is set forth at Section 8 and provides that "any existing licensed acute care hospital may relocate all or a portion of its beds to another existing licensed acute care hospital located within the same subarea." There are no "common ownership" requirements applicable to the transferor and transferee hospitals nor are there any mileage restrictions applicable to such a transfer (as opposed to current "replacement zone" provision that allows transfers within the same subarea if the hospitals are located within 2 miles of each other (for counties with a population of 200,000 or more) or within 5 miles of each other (for counties with a population of less than 200,000)).

The CON Commission is expected to take final actions on the proposed standards at its next meeting scheduled for June 10, 2003 at 10 AM. If approved, the standards will be sent to a joint committee of the legislature and the Governor for a 45-day review period. It is possible that the standards could take effect in August of 2003.

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MCL § 333.22203(9) and (10)

(9) "Covered capital expenditure" means a capital expenditure of $2,500,000.00 or more, as adjusted annually by the department under section 22221(g), by a person for a health facility for a single project, excluding the cost of nonfixed medical equipment, that includes or involves the acquisition, improvement, expansion, addition, conversion, modernization, new construction, or replacement of a clinical service area.

(10) "Covered clinical service", except as modified by the commission under section 22215, means 1 or more of the following: (a) Initiation or expansion of 1 or more of the following services:
(*i*) Neonatal intensive care services or special newborn nursing services.
(*ii*) Open heart surgery.
(*iii*) Extrarenal organ transplantation.
(b) Initiation, replacement, or expansion of 1 or more of the following services:
(*i*) Extracorporeal shock wave lithotripsy.
(*ii*) Megavoltage radiation therapy.
(*iii*) Positron emission tomography.
(*iv*) Surgical services provided in a freestanding surgical outpatient facility, an ambulatory surgery center certified under title XVIII, or a surgical department of a hospital licensed under part 215 and offering inpatient or outpatient surgical services.
(*v*) Cardiac catheterization.
(*vi*) Fixed and mobile magnetic resonance imager services.
(*vii*) Fixed and mobile computerized tomography scanner services.
(*viii*) Air ambulance services.
(c) Initiation or expansion of a specialized psychiatric program for children and adolescent patients utilizing licensed psychiatric beds.
(d) Initiation, replacement, or expansion of a service not listed in this subsection, but designated as a covered clinical service by the commission under section 22215(1)(a).

MCL § 333.22209

Sec. 22209. (1) Except as otherwise provided in this part, a person shall not do any of the following without first obtaining a certificate of need:
(a) Acquire an existing health facility or begin operation of a health facility at a site that is not currently licensed for that type of health facility.
(b) Make a change in the bed capacity of a health facility.
(c) Initiate, replace, or expand a covered clinical service.
(d) Make a covered capital expenditure.

(2) A certificate of need is not required for a reduction in licensed bed capacity or services at a licensed site.

(3) Subject to subsection (9) and if the relocation does not result in an increase of licensed beds within that health service area, a certificate of need is not required for any of the following:

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(a) The physical relocation of licensed beds from a hospital site licensed under part 215 to another hospital site licensed under the same license as the hospital seeking to transfer the beds if both hospitals are located within a 2-mile radius of each other.
(b) Subject to subsections (7) and (8), the physical relocation of licensed beds from a hospital licensed under part 215 to a freestanding surgical outpatient facility licensed under part 208 if that freestanding surgical outpatient facility satisfies each of the following criteria on December 2, 2002:
(i) Is owned by, is under common control of, or has as a common parent the hospital seeking to relocate its licensed beds.
(ii) Was licensed prior to January 1, 2002.
(iii) Provides 24-hour emergency care services at that site.
(iv) Provides at least 4 different covered clinical services at that site.
(c) Subject to subsections (7) and (8), the physical relocation of licensed beds from a hospital licensed under part 215 to another hospital licensed under part 215 within the same health service area if the hospital receiving the licensed beds is owned by, is under common control of, or has as a common parent the hospital seeking to relocate its licensed beds.

(4) Subject to subsection (5), a hospital licensed under part 215 is not required to obtain a certificate of need to provide 1 or more of the covered clinical services listed in section 22203(10) in a federal veterans health care facility or to use long-term care unit beds or acute care beds that are owned and located in a federal veterans health care facility if the hospital satisfies each of the following criteria:
(a) The hospital has an active affiliation or sharing agreement with the federal veterans health care facility.
(b) The hospital has physicians who have faculty appointments at the federal veterans health care facility or has an affiliation with a medical school that is affiliated with a federal veterans health care facility and has physicians who have faculty appointments at the federal veterans health care facility.
(c) The hospital has an active grant or agreement with the state or federal government to provide 1 or more of the following functions relating to bioterrorism:
(*i*) Education.
(*ii*) Patient care.
(*iii*) Research.
(*iv*) Training.

(5) A hospital that provides 1 or more covered clinical services in a federal veterans health care facility or uses longterm care unit beds or acute care beds located in a federal veterans health care facility under subsection (4) may not utilize procedures performed at the federal veterans health care facility to demonstrate need or to satisfy a certificate of need review standard unless the covered clinical service provided at the federal veterans health care facility was provided under a certificate of need.

(6) If a hospital licensed under part 215 had fewer than 70 licensed beds on December 1, 2002, that hospital is not required to satisfy the minimum volume requirements under the certificate of need review standards for its existing operating rooms as long as those operating rooms continue to exist at that licensed hospital site.

(7) Before relocating beds under subsection (3)(b), the hospital seeking to relocate its beds shall provide the information requested by the department of consumer and industry services that will

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allow the department of consumer and industry services to verify the number of licensed beds that were staffed and available for patient care at that hospital as of December 2, 2002. A hospital shall transfer no more than 35% of its licensed beds to another hospital or freestanding surgical outpatient facility under subsection (3)(b) or (c) not more than 1 time after the effective date of the amendatory act that added this subsection if the hospital seeking to relocate its licensed beds or another hospital owned by, under common control of, or having as a common parent the hospital seeking to relocate its licensed beds is located in a city that has a population of 750,000 or more.

(8) The licensed beds relocated under subsection (3)(b) or (c) shall not be included as new beds in a hospital or as a new hospital under the certificate of need review standards for hospital beds. One of every 2 beds transferred under subsection (3)(b) up to a maximum of 100 shall be beds that were staffed and available for patient care as of December 2, 2002. A hospital relocating beds under subsection (3)(b) shall not reactivate licensed beds within that hospital that were unstaffed or unavailable for patient care on December 2, 2002 for a period of 5 years after the date of the relocation of the licensed beds under subsection (3)(b).

(9) No licensed beds shall be physically relocated under subsection (3) if 7 or more members of the commission, after the appointment and confirmation of the 6 additional commission members under section 22211 but before June 15, 2003, determine that relocation of licensed beds under subsection (3) may cause great harm and detriment to the access and delivery of health care to the public and the relocation of beds should not occur without a certificate of need.

(10) An applicant seeking a certificate of need for the acquisition of an existing health facility may file a single, consolidated application for the certificate of need if the project results in the acquisition of an existing health facility but does not result in an increase or relocation of licensed beds or the initiation, expansion, or replacement of a covered clinical service. Except as otherwise provided in this subsection, a person acquiring an existing health facility is subject to the applicable certificate of need review standards in effect on the date of the transfer for the covered clinical services provided by the acquired health facility. The department may except 1 or more of the covered clinical services listed in section 22203(10)(b), except the covered clinical service listed in section 22203(10)(b)(*iv*), from the minimum volume requirements in the applicable certificate of need review standards in effect on the date of the transfer, if the equipment used in the covered clinical service is unable to meet the minimum volume requirements due to the technological incapacity of the equipment. A covered clinical service excepted by the department under this subsection is subject to all the other provisions in the applicable certificate of need review standards in effect on the date of the transfer, except minimum volume requirements.

(11) An applicant seeking a certificate of need for the relocation or replacement of an existing health facility may file a single, consolidated application for the certificate of need if the project does not result in an increase of licensed beds or the initiation, expansion, or replacement of a covered clinical service. A person relocating or replacing an existing health facility is subject to the applicable certificate of need review standards in effect on the date of the relocation or replacement of the health facility.

(12) As used in this section, "sharing agreement" means a written agreement between a federal veterans health care facility and a hospital licensed under part 215 for the use of the federal veterans health care facility's beds or equipment, or both, to provide covered clinical services.

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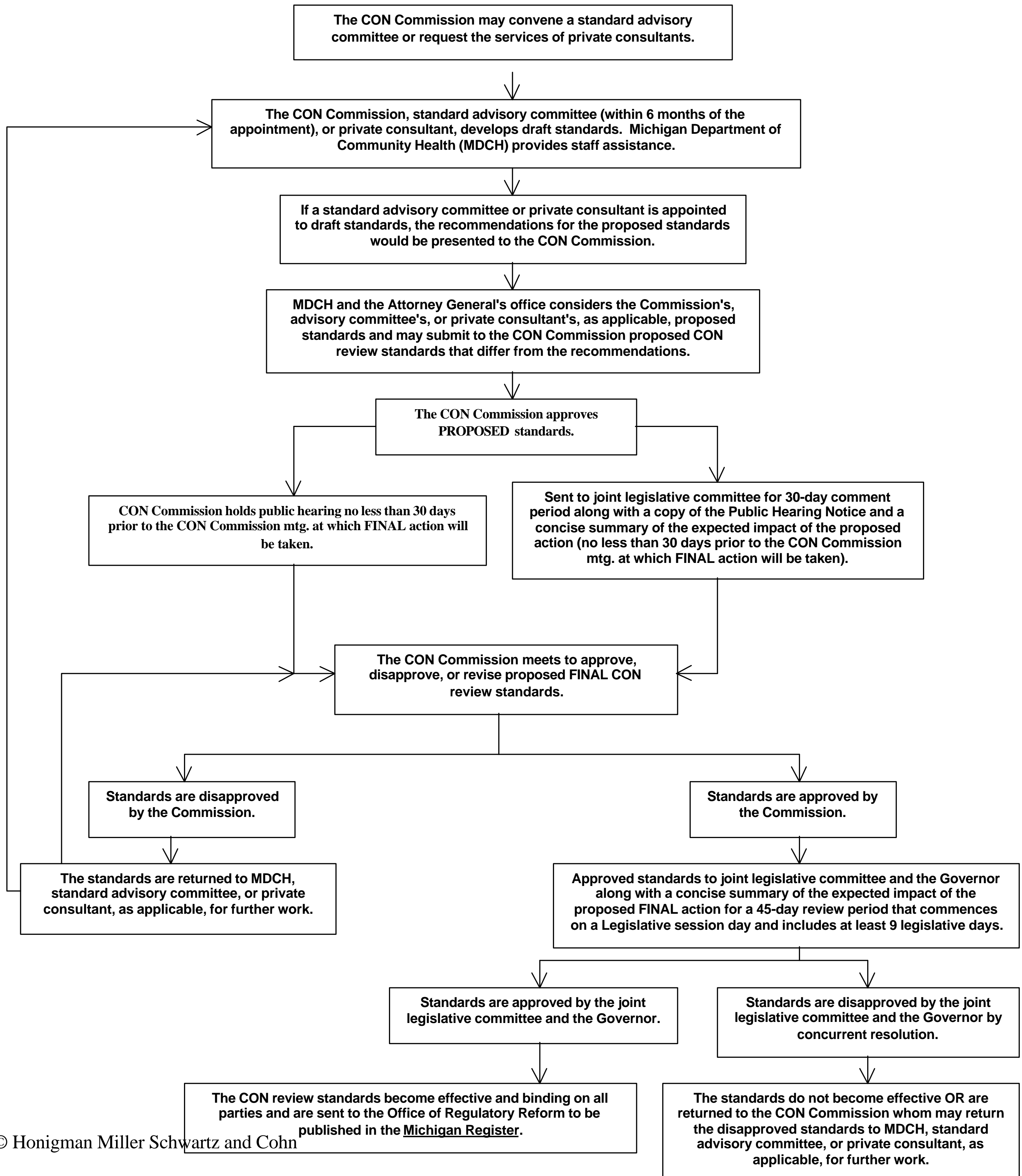
PROCESS FOR DEVELOPING CERTIFICATE OF NEED (CON) REVIEW STANDARDS PURSUANT TO SECTION 22215



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RECENT DEVELOPMENTS IN BUSINESS IMMIGRATION LAW

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I. NEW DEPARTMENT OF HOMELAND SECURITY AND THE DISSOLUTION OF THE INS

The Immigration and Naturalization Service ("INS") ceased to exist on March 1, 2003. The previous functions of the INS have been transferred into three different business bureaus of the Department of Homeland Security ("DHS"). The DHS came into existence on January 24, 2003, and was created as a result of legislation signed by President Bush on November 25, 2002. The three business bureaus of the DHS are as follows:

1. The Bureau of Citizenship and Immigration Services ("BCIS"), which is responsible for the adjudication of immigration-related applications and immigration benefits.

2. The Bureau of Customs and Border Protection ("BCBP"), which is responsible for immigration and customs enforcement at the border.

3. The Bureau of Immigration and Customs Enforcement ("BICE"), which is responsible for the enforcement of interior immigration and customs.

A. *Practical Issues Resulting From The Transition*

1. Former INS District Offices, Application Support Centers and Service Centers remain in the same locations.

2. Former INS forms and documents issued by the INS continue to be valid and accepted by the BCIS and other agencies. Examples of documents that remain valid as evidence of immigration status include alien registration cards (Green Cards), certificates of citizenship, employment authorization cards (EAD Cards), travel and advance parole documents and Form I-94s.

3. The Department of State ("DOS") remains responsible for the issuance of immigrant and non-immigrant visas. The DHS is responsible for issuing policy and training concerning visa issuance at United States consulates abroad. The DHS and the DOS are currently in the process of developing a memorandum of understanding regarding the roles and responsibilities of each agency.

4. Web/contact information for the DHS
DHS: *www.dhs.gov*
BCIS: *www.immigration.gov* or *www.bcis.gov* or 800.375.5283
BICE: *www.bice.immigration.gov*
BCBP: *www.customs.gov*

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II. SPECIAL REGISTRATION FOR CERTAIN MALE NONIMMIGRANTS

On September 11, 2002, the BCIS implemented the first phase of the National Security Entry-Exit Registration System ("NSEERS"). The program is now also commonly referred to as "special registration." NSEERS created an entry and exit registration system for nonimmigrant aliens from certain designated countries and other aliens deemed to pose a heightened national security or law enforcement risk.

A. *Port Of Entry Special Registration*

1. <u>Aliens Subject To Port Of Entry Registration</u>

As of September 11, 2002, NSEERS special registration applies to all foreign nationals (male and female) age 14 and over admitted into the United States in a nonimmigrant status whose country of birth or citizenship is Iran, Iraq, Libya, Syria or Sudan. As of October 1, 2002, males between the ages of 16 and 45 whose country of birth or citizenship is Pakistan, Saudi Arabia or Yemen may also be subject to special registration based on criteria established by the Attorney General. Nationals of other countries who are determined to pose an elevated risk by the DOS or an immigration officer at a port of entry may also be subject to special registration.

Special registration does not apply to citizens or permanent residents of the United States, ambassadors, public ministers, career diplomats or representatives of certain international organizations.

2. <u>Procedures For Aliens Registered At Ports Of Entry</u>

If subject to special registration, an alien must be photographed and fingerprinted immediately upon arrival at a United States port of entry. The alien's fingerprints are checked against several databases to determine if the alien is wanted for criminal or terrorist activity or if the alien has previously entered the United States under a different name. The alien must also provide the BCIS with information about the purpose of the alien's stay in the United States, contact information in the United States, and information regarding the alien's history in the alien's home country.

3. <u>Follow-up Obligations For Aliens Registered At Ports Of Entry</u>

a. <u>*Requirement to Re-register*</u> - An alien who remains in the United States for 30 days or longer must appear at a designated BCIS office between day 30 and day 40 to show continued compliance with the terms of the alien's visa and re-register. Such aliens must re-register every 12 months after the date of their initial entry, within 10 days of the one year anniversary of the primary registration.

b. <u>*Change of Address Notification*</u> - Registered aliens must provide the BCIS with notice of a change of address, employment or educational

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institution via use of the BCIS Form AR-11 SR, within 10 days of such change.

c. *Departure Notification* - When departing the United States, registered aliens must depart through one of the BCIS's designated ports of departure and appear at a special registration location to register upon departure.

B. *Call-In Special Registration For Aliens Already Present In The United States*

1. **Aliens Subject To Call-In Special Registration**

Certain nonimmigrant aliens already present in the United States as of September 11, 2002, were required to register with a local BCIS office. Four groups of aliens were listed in publications in the Federal Register and the deadlines for registration of each group were extended once. The extended deadline for registration of the last group of aliens was April 25, 2003. The following aliens were subject to the call-in special registration:

a. *Federal Register Notice November 16, 2002* - Male nationals or citizens of Iran, Iraq, Libya, Syria and Sudan, born on or before November 15, 1986, who were inspected and admitted to the United States on or before September 10, 2002, and who were to remain in the United States until December 16, 2002.

b. *Federal Register Notice November 22, 2002* - Male nationals or citizens of Afghanistan, Algeria, Bahrain, Eritrea, Lebanon, Morocco, North Korea, Oman, Qatar, Somalia, Tunisia, United Arab Emirates or Yemen, born on or before December 2, 1986, who were inspected and admitted to the United States on or before September 30, 2002, and who were to remain in the United States until January 10, 2003.

c. *Federal Register Notice December 18, 2002* - Male nationals or citizens of Pakistan and Saudi Arabia born on or before January 13, 1987, who were inspected and admitted to the United States on or before September 30, 2002, and who were to remain in the United States until February 21, 2003.

d. *Federal Register Notice January 16, 2003* - Male nationals or citizens of Bangladesh, Egypt, Indonesia, Jordan or Kuwait, born on or before February 24, 1987, who were inspected and admitted to the United States on or before September 30, 2002, and who were to remain in the United States until March 28, 2003.

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C. *Practical Issues For Employers*

Foreign national employees are subject to special registration if they meet the criteria described above. Upon leaving the country for business or pleasure, including travel to Canada or Mexico, the employee not only must depart through a designated port of departure, but is subject to registration again upon re-entry to the United States. These requirements may impose business travel delays as well as absences from work due to mandatory BCIS office visits.

Further information regarding the special registration program can be found at the BCIS website: *www.immigration .gov*.

III. DEPARTMENT OF STATE SECURITY CHECKS AND VISA DELAYS

A. *Nature of the Problem*

New security screening procedures implemented by the DOS in the past year, including expansion of the technology alert list, have placed a significant strain on the ability of consular posts abroad and the visa office in Washington D.C., to issue visas in a timely and efficient manner. Considerable burdens have also been placed on various other government entities involved in obtaining the necessary clearances for visa issuance. Inevitably, legitimate applicants have been subject to significant delays and uncertainty concerning visa issuance. Although important to the United States' increased efforts to screen out potential criminals and terrorists, the consequences of the extensive security checks now in place have caused confusion and frustration on the part of foreign national employees and employers, and has placed a tremendous stress on the United States economy and United States activities due to workforce shortages, delayed projects, lost business opportunities for United States companies and even loss of jobs in some industries.

A number of interest groups, organizations and associations who assist foreign national employees and employers, as well as groups who promote and assist in international educational and cultural exchange, have written to the DOS to express their concerns. The DOS is working continuously to expedite visa clearances consistent with overriding responsibilities for border security. Some of these measures include adding personnel and introducing additional automation into the process.

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B. *Practical Response For Employers*

Prior to allowing a nonimmigrant employee with an expired visa to depart the United States (with the exception of trips to Canada or Mexico for 30 days or less for purposes other than applying for a visa), an employer should consult with immigration legal counsel for an evaluation of the employee's visa application.

IV. RECENT DEVELOPMENTS IN IMMIGRATION LAW FOR HEALTH CARE PROFESSIONALS

A. *Department Of Health And Human Services J-1 Waiver Sponsorship For Foreign National Physicians*

Upon completion of a J-1 program, foreign national physicians who take part in graduate medical training in the United States, are required to return to their country of nationality or last country of residence for two years prior to returning to the United States in H-1B or immigrant status. A foreign national physician may, however, obtain a waiver of this foreign residence requirement through sponsorship from an interested government agency ("IGA"). The Department of Health and Human Services ("HHS") now acts as an IGA for the purpose of requesting waivers of the two-year foreign residence requirement for foreign national physicians willing to serve for three years in a medically underserved area in the United States.

1. History

The Department of Agriculture ("USDA") sponsored physicians for J-1 waivers until April 2002, when it terminated its participation in the program. On December 19, 2002, HHS assumed the role of sponsoring J-1 waivers. Previously, HHS had restricted its participation as an IGA to sponsorship of researchers conducting research of national or international significance. HHS has now broadened its IGA program to include sponsorship of foreign medical graduates agreeing to serve in Health Professional Shortage Areas ("HPSA") or Medically Underserved Areas and Populations ("MUA/P") for a period of three years and within one year of completion of a primary care or psychiatric residency program. Eligibility for an HHS waiver is restricted to positions in primary care and general psychiatry.

2. Procedure

HHS reviews waiver applications submitted by health care facilities and institutions, verifies foreign national physicians credentials, and makes recommendations to the DOS. The DOS forwards a favorable recommendation to the BCIS for issuance of the waiver approval notice. Once the waiver is approved by BCIS, the health care employer files a petition with the BCIS for H-1B status for the foreign national physician. The petitioning health care provider must

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establish that it has recently, and in good faith, recruited for United States physicians and has been unable to obtain a qualified physician.

The waiver process should be commenced while the foreign national physician is still completing his or her residency so that the process can be completed before the physician's authorized period of J-1 status expires.

B. *Conrad J-1 Waiver Program For Foreign National Physicians*

The Conrad J-1 waiver program allows States to request waivers of the two-year foreign residence requirement for foreign national physicians receiving graduate medical training in the United States who agree to serve in medically underserved areas for three years in exchange for the waiver.

The 21st Century Department of Justice Appropriations Authorization Act signed in November 2002, included a provision to extend the Conrad State 20 waiver program until 2004 and increase the number of state waivers available from 20 to 30.

The Michigan Department of Community Health recently announced that it will be accepting applications for its Conrad waiver program during the period of June 9, 2003 through June 13, 2003. To obtain an application packet, submit a check for $50 payable to the Michigan Health Council, 2410 Woodlake Drive, Okemos, MI 48864, and include the physician's full name, specialty and graduation date (from residency).

C. *Foreign National Nurses*

1. Immigrant Petitions for Nurses

The United States Department of Labor ("DOL") has provided guidance to the BCIS with respect to the approval of I-140, immigrant petitions for foreign nurses based on Schedule A (pre-certified) labor certification. In the past, in order for the BCIS to approve an I-140 for a Schedule A nurse, the nurse must have either 1) passed the Commission on Graduates of Foreign Nursing Schools ("CGFNS") examination, or 2) hold a full and unrestricted (permanent) license to practice nursing in the State of intended employment. Some States, however, do not require that a nurse pass the CGFNS in order to obtain a license, provided the nurse passes the National Council Licensure Examination for Registered Nurses ("NCLEX-RN") examination. In those states, a serious problem arose because the nurse who had passed the NCLEX-RN exam could not obtain a license without a Social Security Number. In turn, the Social Security Administration refused to issue a Social Security Number to a foreign national without work authorization in the United States.

The DOL and BCIS, have now clarified that an I-140 immigrant petition for a Schedule A nurse may be approved based on evidence that the nurse has passed the NCLEX-RN examination. In lieu of presenting evidence of a State license,

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the BCIS will accept documentation that the foreign nurse has passed the NCLEX-RN examination, because passage of the exam renders the foreign nurse eligible for the State license. The BCIS will now favorably consider an I-140 petition for a Schedule A nurse upon receipt of a certified letter from the State of intended employment confirming that the nurse has passed the NCLEX-RN examination and is eligible to receive a license to practice nursing in that State (but for the lack of a Social Security Number).

2. H-1B Status For Foreign Nurses

BCIS headquarters has recently issued guidance to BCIS Service Centers regarding the eligibility of foreign nurses to receive H-1B status. The guidance confirms the long standing position of the BCIS that as a general rule typical RN positions do not qualify for H-1B status because the position is not considered a specialty occupation in that it does not require the attainment of a bachelor degree or higher degree as a minimum entry requirement for the position. Most RN positions only require a two-year associate degree. One exception to this general rule is for RNs licensed to practice in the State of North Dakota. A Bachelor of Science degree in Nursing is a prerequisite to obtaining a license to practice nursing in the State of North Dakota. Therefore, the position of RN at a facility in North Dakota does qualify for H-1B status.

The BCIS guidance clarifies that beyond the typical RN position, some types of specialty RN positions do require the attainment of a bachelor degree and, therefore, do qualify for H-1B status. In order to qualify an RN position for H-1B status, a petitioning employer must meet the following requirements:

a) a bachelor or higher degree (or its equivalent) is normally the minimum requirement for entry into the positions;

b) the degree requirement is common to the industry for parallel nursing positions (for example, employers in the same industry require their employees to hold the degree when they are employed in the same or a similar position);

c) the employer normally requires a degree or its equivalent for the position; or

d) the nature of the position's duties is so specialized and complex that the knowledge required to perform the duties is usually associated with the attainment of a bachelor or higher degree (or its equivalent).

The BCIS has confirmed that certain advanced practice nursing positions generally do require a bachelor degree or higher degree and therefore, also qualify

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for H-1B status. Positions that require a nurse to be certified as an advanced practice registered nurse will generally qualify for H-1B status. Examples of these types of positions are as follows: Clinical Nurse Specialist; Nurse Practitioner; Certified Registered Nurse Anesthetist; and Certified Nurse-Midwife. Certain other nurse management/administrative positions may also qualify for H-1B status. These positions typically require a bachelor degree and in some cases a graduate degree in nursing or health administration.

Note: This material is intended to provide information but not legal advice regarding any particular situation. Anyone requiring legal advice regarding a specific situation should contact an attorney.

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HONIGMAN MILLER SCHWARTZ AND COHN LLP
HEALTH LAW UPDATE 2003
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Materials by Linda S. Ross

SELECT RECENT DEVELOPMENTS IN SELF REFERRAL AND ANTI-KICKBACK LAWS

I. Self Referral Law Developments

A. Michigan Public Health Code. Amendment to MCLA 333.16221(e)(iv) with respect to what constitutes "unprofessional conduct."

1. Public Health Code authorizes the Michigan Department of Consumer and Industry Services ("MDCIS") to investigate the conduct and practices of licensed health professionals.

2. Unprofessional conduct includes "directing or requiring an individual to purchase, or secure a drug, device, treatment, procedure or service from another person, place, facility or business in which the licensee has a financial interest."

3. Historically, the provisions on unprofessional conduct were interpreted to prohibit referrals by a physician to an entity partially owned by the physician even when the physician disclosed his or her ownership interest in the entity and gave patients the option to be referred elsewhere.

4. By amendment, effective June 3, 2002, the definition of unprofessional conduct at Section 16221(e)(iv) was changed.

5. Different provisions apply to physician licensees and non-physician licensees regarding what constitutes unprofessional conduct.

   a. Non-physician licensees engage in unprofessional conduct when requiring an individual to purchase or secure a device, drug, treatment, procedure or service from another person, place facility or business in which the non-physician licensee has a financial interest.

   b. Physician licensees engage in unprofessional conduct when they make referrals for "designated health services" in violation of the Stark Law to an entity with which the physician has a financial relationship within the meaning of the Stark Law.

   c. Unless an applicable exception is met, the Stark Law generally prohibits a physician from referring a patient to an entity for certain services if the physician (or his or her immediate family) has a financial (compensation or ownership) relationship with the entity and reimbursement for the service is from a federal health program.

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d. Physicians who make permitted referrals must accept a proportionate share of Medicaid patients and, with limited exceptions, accept Medicaid or Medicare payment as payment in full when the physician refers a person to an entity in which he or she has a financial relationship.

6. Penalties for Unprofessional Conduct.

a. Can range from fines and reprimands to revocations of the professional license of a licensee.

7. Key Implications of Amendment.

a. Michigan law applies Stark provisions to all payors and not just to certain federal payors.

b. Future revisions to Stark Law may be incorporated into Michigan law if the revisions pertain to physicians and protect the public.

c. The Stark Law does not prohibit a non-physician licensee from directing or suggesting or otherwise influencing someone's judgement to purchase or obtain a drug, device or medical service from a facility in which the non-physician licensee has a financial interest.

d. Physicians have greater opportunities to refer patients to places in which the physician has an ownership interest (*e.g.*, ambulatory surgery centers) because the prohibition is now linked to designated health services and not all services previously covered by the Michigan statute are designated health services.

e. On the other hand, compensation arrangements between physicians and facilities (even if the physician does not have an ownership in the facility) now are subject to this state self-referral law. This broadens the reach of the Michigan statute.

f. Potentially greater competition between hospitals and physician to provide services and treatment to patients. Physicians are now able to enter into transactions involving non-DHS and/or that meet a Stark Law exception without violation state law.

B. Stark Law.

1. Third delay in effective date of provisions in Stark Law Phase 1 regulations rejecting percentage compensation arrangements as "set in advance." Delay is until January 7, 2004.

2. Phase II Stark regulations are anticipated by January 7, 2004.

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II. Anti-Kickback Statute Developments

A. Review. The Anti-kickback Statute makes it unlawful to knowingly and willfully solicit, receive, offer or pay remuneration (*i.e.*, anything of value) to induce or reward referrals of items or services payable by a federal health care program. Violations are felonies punishable by a maximum fine of $25,000, imprisonment for up to five years or both. Civil monetary penalties up to $50,000 and exclusion from Medicare and other federal health programs also are possible. If only one purpose of the remuneration involved is to obtain money for the referral of services or to induce further referrals, the statute may be violated.

B. OIG Advisory Opinion No. 03-5 (re: Joint Ownership of Ambulatory Surgery Center); February 6, 2003.

1. Dealt with a proposed ambulatory surgery center ("ASC") to be structured as a limited liability company ("LLC") jointly owned by a hospital and multi-specialty group practice. Several physicians in group would not personally use the ASC.

2. The LLC would plan, develop and operate the ASC and have it certified by Medicare. The hospital would own 49% of the ASC and the multi-specialty group would own 51%. Each investor's return would be proportional to its investment. The ASC would have an open medical staff and would be located on land owned by hospital and leased to LLC. The physician group had 52 shareholder employee physicians and employed other physicians and health professionals (physical therapists, optometrists, nurse practitioners). Some of the physicians were surgeons but most were not. Physician compensation would be determined independent of referrals or the volume of procedures performed at the ASC.

3. OIG reviewed potentially applicable safe harbors, including the space rental safe harbor and the safe harbor for investment interests in ASCs owned jointly by hospitals and physicians (*See*, 42 CFR 1001.952(r)(4)). The ASC safe harbor requires investing physicians in a position to refer patients to the ASC to only invest as individuals who meet the requirements for surgeon-owned ASCs, single specialty ASCs or multi-specialty ASCs as set forth in the safe harbor or as group practices consisting of physicians or surgical group practices. In this case, the investing physicians in the ASC were doing so via a multi-specialty group practice. Therefore, they had to meet the requirements applicable to the group practice safe harbor and the group must consist of physicians who meet one-third (1/3) practice income test and the one-third (1/3) practice test. Those tests require at least one-third (1/3) of each physician investor's medical practice income from all sources during the prior fiscal year or twelve (12) month period to be derived from the physician's performance of procedures, and one-third (1/3) of the procedures performed during such period to have been performed at the investment entity.

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4. OIG noted that surgical center joint ventures that include physicians in a position to generate surgical business are subject to fraud and abuse and that the safe harbor was narrowly tailored to minimize such risks by applying only to physicians unlikely to use the investment as a vehicle for profiting from their referrals to other physicians using the ASC. In other words, the safe harbor protects only physician investors actually using the ASC regularly as part of their medical practice or who practice in the same specialty as other physician investors and are, therefore, unlikely to refer significant business to competing physician investors when they can earn the fees themselves. In this case, the majority of the physicians in the multi-specialty group did not fit either category and there was a likelihood of cross-specialty referrals for ASC services. Additionally, only a few of the group physicians would use the ASC or part of his or her medical practice. Thus, the concern exists that the arrangement would be used to reward referrals. Therefore, the OIG could not conclude that the arrangement had minimal risk of fraud and abuse.

5. OIG concluded that the arrangement had the potential for generating prohibited remuneration under the Anti-kickback Statute and to result in the imposition of administrative sanctions. A conclusive determination, however, would be based on the parties' intent and that determination was beyond the scope of the advisory opinion process.

C. OIG Advisory Opinion No. 03-8 (re: Management of Distinct Part Rehabilitation Unit); April 3, 2003. Management of Rehabilitation Unit.

1. Addresses whether a company that seeks to manage distinct part inpatient units in general acute care hospitals in return for a management fee determined on a per patient per day basis runs afoul of the Anti-kickback State.

2. Key aspects of the proposed arrangement include:

a. Three year management contract.

b. Manager develops and operates the unit, provides all patient care personnel except nurses (who will be furnished by the hospital).

c. Manager provides a leadership team, including a program director, community outreach coordinator and medical director (a hospital staff physician retained by the company as an independent contractor pursuant to an agreement that meets the personal services safe harbor under the Anti-kickback Statute and the personal services exception to the Stark Law).

d. The leadership team would have contact (via one-on-one meetings, group educational programs and workshops, *etc*.) with physicians, discharge planners and utilization review personnel of third party payors who might have influence over patient referrals to the unit. No direct solicitation of patients would occur.

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e. Each hospital would pay the Manager a monthly management fee based on a per patient per day basis. The company certified that the fee would reflect fair market value. The hospital would bill for all charges for services provided in the unit except for physician fees which would be billed by the physicians.

f. OIG next reviewed safe harbors to the Anti-kickback Statute noting that the personal services and management safe harbor potentially applied to the proposed transaction. The arrangement failed to meet that exception because the aggregate compensation paid by the hospitals to the company would not be set in advance. Therefore, the OIG noted that the arrangement would be subject to scrutiny to determine, based on all of the facts and circumstances, whether the potential risk of fraud and abuse is sufficiently low to impose protection prospectively. Noting that "per patient" payment arrangements are disfavored under the Anti-kickback Statute due to their potential to promote over-utilization and unnecessary lengths of stay, the OIG was unable to find that the risks of the arrangement were sufficiently low to "bless" it in advance. The factors influencing the OIG's decision were:

- Manager and hospital have the same incentives to fill the rehabilitation beds even though payment is fixed irrespective of length of stay.

- Even though 75% of the unit patients must have at least 1 of 10 specific conditions those conditions could be manipulated, and the other 25% could have more diffuse symptoms or conditions.

- Nurses performing pre-admission screenings as hospital employees have the same incentive as the manager to make the unit successful.

- Medical Director is in a position to influence referrals.

- Manager would be engaged in community outreach, including marketing.

- Even if per patient per day reflected actual costs, it could simply veil a success fee.

3. OIG concluded that the arrangement could result in prohibited remuneration under the Anti-kickback Statute and give rise to administrative sanctions on the company. The OIG noted that any definitive conclusion as to whether the arrangement violates the Anti-kickback Statute would require a determination of the parties' intent, a determination beyond the scope of the advisory opinion process.

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D. <u>OIG Special Advisory Bulletin on Contractual Joint Ventures; April 23, 2003</u>

1. Cautions health care providers who serve Medicare and Medicaid beneficiaries against entering into contractual joint ventures that reward the provider for improper patient referrals in violation of the federal Anti-kickback Statue.

2. Concern relates to complex arrangements that disguise illegal kickbacks through the use of a combination of "shell" entities and subcontracts with freestanding providers of related services. An example is when a group of nephrologists establish a wholly-owned company to provide home dialysis supplies to its dialysis patients and the company contracts with an existing supplier of home dialysis supplies to operate the new company and to provide all goods and services to the new company. In such arrangements, the manager/supplier provides day-to-day management, billing, equipment, personnel, space, training and health care items, supplies and services.

3. The underlying federal Anti-kickback Statute concern is that these arrangements and kickbacks may result in over-utilization, increase costs and create unfair competition.

4. Suspect and potentially prohibited contractual arrangements include the following characteristics:

   a. Owner is expanding into a new related business (in an existing entity or subsidiary) that depends entirely on patient referrals from the existing business (*e.g.*, hospital enters into DME business).

   b. The owner does not operate or commit substantial resources to the new business in terms of finances, capital or human resources. Rather, the other entity provides management and other services as well as staff and inventory to run the business. The owner's primary contribution is the referral of patients.

   c. Without the contractual arrangement, the entity with which the owner contracts would be a competitor providing and billing for services in its own right.

   d. Payments to the owner are based on the owner's referrals to the new business. After paying a management or supplier fee to the other entity, the Manager keeps the residual profits.

   e. The aggregate payments to the other entity typically vary with the volume or value of referrals to the new business by the owner.

5. OIG cautions that while parties may try to fit some of these arrangements into a safe harbor to the Anti-kickback Statute, some safe harbors may not apply. For example, if a manager offers a discount to an owner for items and services to be provided in one of these contractual joint ventures, the discount safe harbor would

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not apply because it does not protect discounts offered by a seller to a buyer in a common enterprise because it is not an arm's length transaction. The OIG also notes that the opportunity for the owner to generate a fee may implicate the Anti-kickback Statute even if the management/supplier fee meets a safe harbor.

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Materials by Gerald M. Griffith

V. Joint Venture Developments – Continued

A. IRS View of Nonprofit/For-profit Joint Ventures

1. *IRS Two-prong Test for Nonprofit/For-profit Joint Ventures*

Hospital-physician joint ventures remain a hot topic. Where the venture partner is a nonprofit, tax-exempt entity, however, its tax-exempt status may be affected by the venture or the venture may generate UBI that is taxable to the nonprofit. Those tax consequences also may lead to intermediate sanctions (penalty excise taxes) on the for-profit or physician partners under Section 4958 of the Code and may raise concerns over appropriate use of bond-financed facilities (which in turn could jeopardize the exemption of interest on the bonds).

The IRS generally applies a two-prong test in determining whether or not participation as a general partner in a partnership jeopardizes a nonprofit's 501(c)(3) status, asking: (a) whether participation furthers a charitable purpose of the nonprofit (purpose test); and (b) whether the nonprofit's duties to its partners preclude it from acting exclusively in furtherance of its exempt purposes (control test). For approximately 15 years, the IRS approved a number of 50/50 ancillary joint ventures under this standard. In recent years, however, IRS guidance has been limited for ancillary joint ventures. Instead, both the IRS and the courts have focused on whole entity joint ventures (*e.g.*, Rev. Rul. 98-15, *Redlands*).

These recent decisions and the IRS' position in *St. David's* (discussed below) reflect a heightened level of focus on control aspects of joint ventures as the key determinant of whether a nonprofit's participation satisfies the two-prong test. Specifically, the concern is not only whether fiduciary duties to partners conflict with exempt purposes, but whether the nonprofit retains sufficient affirmative control to not only veto bad acts by the joint venture but rather to compel good ones – to be able to ensure that the joint venture takes action that furthers the nonprofit's exempt purposes. Various rulings and other guidance from the IRS also make it clear that, in the IRS' view, the same rules apply to both ancillary joint ventures and whole hospital joint ventures. The consequences of failing to measure up, however, may be less drastic for ancillary joint ventures. In some cases those risks may be limited to UBI rather than exemption risk, at least where the other parties are not insiders.

2. *St. David's Whole Hospital Joint Venture*

In a decision issued on the eve of trial, the U.S. District Court granted summary judgment to St. David's Health Care System, Inc. ("St. David's"), restoring its tax-exempt status in a decision and taking a liberal view of the stringent control standards that the IRS outlined in Rev. Rul. 98-15. St. David's formed a partnership ("St. David's Health Care Partnership") with Round Rock Hospital, Inc., an affiliate of HCA (formerly "Columbia/HCA"), in 1996 to operate all of the partners' hospitals and related health care businesses in the Austin, Texas area (which included substantially all of St. David's charitable assets). Round Rock was the managing partner and another HCA affiliate was a limited

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partner. St. David's held both general and limited partnership interests, for a total ownership interest of 45.9% (10% as general partner) as compared to 54.1% for the HCA entities (10% as general partner). The partnership also entered into a Management Services Agreement with an HCA affiliate with a term of over 50 years.

The IRS had originally issued a favorable private letter ruling (unpublished) on the joint venture. Following an audit of St. David's for the 1996 to 1998 tax years; however, the IRS issued a Technical Advice Memorandum (also unpublished) in October 2000 revoking its exempt status. St. David's paid $885,072 in corporate income tax, interest and penalties then filed a claim for a refund, which was disallowed. It then filed a refund suit in U.S. District Court for the Western District of Texas, challenging the revocation. St. David's asserted that its share of profits from the venture and invested capital are used for the charitable purposes of improving patient care and expanding health care facilities.

For its part, the IRS argued that St. David's was no longer operated primarily to further a charitable purpose, and that it was operated for the private benefit of HCA rather than the community. The Service based its position on allegations (a) that the partnership did not provide sufficient true charity care at its hospitals for them to be operated in a charitable manner (*i.e.*, the partnership did not further St. David's charitable purposes), (b) that St. David's was not controlled by a community board, and (c) that HCA received an impermissible private benefit from the partnership.

The court soundly rejected the Service's characterization of St. David's purposes. With respect to the amount of charity care provided, the court noted that Revenue Ruling 69-545 expressly eliminated any charity care requirement (at least for hospitals with an open ER like the St. David's hospitals) and that the promotion of health is clearly a charitable purpose. The court also failed to attach any significance to a factor deemed significant by the IRS in the past – that the partnership was managed by an affiliate of the for-profit under a long-term (more than 50 years) contract.

As for the community board argument, the court found that presence of a community board is a favorable "major factor" but not a requirement for exemption under Rev. Rul. 69-545. The court also distinguished *Redlands* (a joint venture case decided in the IRS' favor) on the grounds that St. David's had two other favorable community benefit factors missing in *Redlands*: an emergency room open to all and indigent care. The court made no mention of the effect of EMTALA requirements that ERs (nonprofit and for-profit alike) accept all patients presenting in an emergent condition. Likewise, the court took a broad view of "indigent care" and the manner in which St. David's distinguished between charity care and bad debt. It rejected the Service's argument that uncompensated care is not true charity care if a hospital first attempts to collect payment before deciding whether to classify free care as charity care or bad debt. The court noted that the Service's view implicitly would require hospitals to determine whether or not they can expect payment before any care as rendered – a procedure which the court found theoretical and impractical.

Assuming that a community board is a requirement for exemption, the court further found that the St. David's partnership actually was governed by a community board. In this case, the partnership board was appointed 50/50 by Round Rock and St. David's. The court found, however, that board composition is not a dispositive factor; rather, the proper standard is that the board must be structured "to ensure that the community's interests are given precedence over any private interests." In analyzing

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whether the St. David's board met that standard, the court focused on several elements relevant to control of the partnership. The court found it significant that there were other protections beyond the 50/50 veto rights of the nonprofit: (1) the partnership agreement requires that the partnership operate all of its hospitals (including the HCA hospitals) in accordance with the community benefit standard of Rev. Rul. 69-545, including an obligation to accept Medicare and Medicaid patients, accept all patients regardless of ability to pay (whether or not in an emergent condition, which goes beyond 69-545), maintain an open medical staff, provide community health education programs and generally promote the health of the community; (2) St. David's has the unilateral right to dissolve the partnership for breach of the community benefit standard (and, though not mentioned in the opinion, the right to terminate the management agreement); (3) the board chair must be a member appointed by St. David's, thus giving St. David's "great control over the board's agenda"; and (4) St. David's has the right to unilaterally remove the CEO. In other words, the court found that majority board representation is not absolutely necessary for a nonprofit to have sufficient control of a joint venture. With *St. David's*, providers have their first guidance as to what other, structural factors may suffice to demonstrate that control.

Finally, as to private benefit, the court echoed the same indicia of control outlined above. It noted that "it is difficult to imagine a corporate structure more protective of an organization's charitable purpose than the one at issue in this case." The clear statement of purpose charitable in the partnership agreement (i.e., to operate the hospitals in accordance with the IRS' own community benefit standard) and the other rights of the nonprofit combined, in the court's view, to give St. David's "substantially more control than the for-profit partner, despite the facial 50-50 split in voting rights on the Board of Governors."

Several points in *St. David's* are potentially significant for health care joint ventures. First, equity ownership itself is not determinative if there is requisite control to avoid misuse of charitable assets (here the exempt organization had a minority equity ownership interest yet did have slightly more than 50% control in the court's opinion). Second, reserved powers and initiation rights can tip the balance in a 50/50 joint venture. Third, courts may give a broader reading to "promotion of health" than the IRS in assessing charitable purposes, which in this case included all uncompensated care not just the traditional charity care for those unable to pay. Fourth, a community board for the joint venture entity is not a requirement for exemption of the nonprofit joint venture partner but only one factor.

The IRS has appealed the District Court decision and at the time this outline was completed, the matter was pending before the Fifth Circuit Court of Appeals. In its brief on appeal, the government has again attacked the lack of sufficient control for the tax-exempt partner in the whole hospital joint venture, as well as insisting that the joint venture must render some meaningful amount of true charity care (as distinguished from bad debt) in order for the tax-exempt partner to remain exempt. The IRS also views the statement of charitable purposes in the Partnership Agreement as insufficient because it failed to expressly subordinate any profit motive to charitable purposes. Although a more flexible position on 50/50 joint ventures with for-profits may ultimately result from the IRS' loss in *St. David's*, until the appeal is decided, it seems unlikely that the IRS will change its ruling and audit positions on the importance and indicia of control in joint ventures (both whole hospital and ancillary joint ventures). In other words, while the *St. David's* decision is clearly very favorable to nonprofit and for-profit providers seeking to joint venture on equal terms, it is far too early to tell what impact it will ultimately have on the IRS' view of such joint ventures. A conservative approach must still be mindful of the IRS' view

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when planning joint ventures. Existing and more aggressive ventures can take some measure of comfort from the favorable outcome in *St. David's*; however, recent IRS rulings on ancillary joint ventures for MRI services (TAM 200218037) and a Cardiac Cath Lab (PLRs 200304041-042) continue to reflect the IRS' more stringent view of the control test. The latter rulings, however, do contain a slight silver lining for physicians on the control test. Specifically, in those rulings the IRS did not object to a provision in the Operating Agreement that absolves the physician board members from liability for breach of the fiduciary duty of loyalty (a) if the nonprofit's representatives vote down a proposed activity or action, or (b) by reason of the subordination of the profit motive.

B. Nonprofit and Charitable Trust Issues for Joint Ventures

1. Charitable Trust Audits

In part of a growing national trend to more closely monitor nonprofit corporations on a state level, Minnesota's Attorney General conducted a charitable trust audit of Allina Health System in 2001. The audit focused on IDS/HMO operations and misuse of charitable assets contrary to corporate purposes. Although the Allina audit did not involve a joint venture, the questions asked are ones that are as relevant to a joint venture as to an IDS. Allegations made by the Attorney General in the course of that audit included alleged mismanagement and misuse of nonprofit, charitable assets, including use of HMO's funds to shore up the Allina hospitals and clinics. He also criticized the HMO's spending approximately 47% of premium dollars on administrative expenses (Allina insisted the figure was only 10%) and specifically challenged the management fees paid to a for-profit management company suggesting that they were over-priced by about 50% and that Medica should have negotiated a better deal and sought competitive bids. Even before the Sarbanes Oxley Act was passed, the Attorney General questioned Allina's expenditures for consulting fees (approximately $20 million in 1999) and its use of a Big Five firm to provide consulting services at the same time it was acting as the company's independent auditor thereby affecting the auditor's independence and credibility. The AG also challenged several aspects of executive compensation, including payment of various personal expenses, spousal and luxury travel, and payment of executive bonuses despite those bonuses being tied to financial goals that apparently were not met. The bottom line for the Attorney General though appeared to be his perception that the HMO/health system combination presented an irreconcilable conflict of interest that was likely to result in increased health care costs for consumers.

Nor is the Allina audit an isolated example. Minnesota's AG raised many of the same concerns in a subsequent audit of HealthPartners, including allegations of excessive compensation for executives, lack of appropriate board oversight of executive compensation, inappropriate travel and entertainment expenses, overspending on consultants, ignoring internal policies on retention of consultants, and paying out millions to consultants (including an affiliate) without written contracts.

2. Other Recent State Enforcement Initiatives

There are several examples of activist regulators in other states that have made headlines. Two of the more recent examples involved major health care transactions:

(a) Health Midwest: A major nonprofit system with hospitals and health care facilities in two states entered into an agreement to sell most of its assets to HCA. Negotiations with the State AG broke down and resulted in bitter litigation. In the end, the sale was approved in court, but only after turning over control of substantially all of the net proceeds to the AGs in Kansas and Missouri. The AGs

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focused on a variety of factors, including impact of the transactions on the communities, the allocation of proceeds between the two states, control of any surviving foundation and executive compensation packages (in the nature of golden parachutes, with the CEO agreeing with the Missouri AG to repay 50% of his $1 million 2002 salary).

(b) CareFirst: The Maryland Insurance Commissioner blocked the sale of CareFirst to Wellpoint. The 300 plus page report provides a virtual road map of what can go wrong in a major nonprofit deal. Four key take aways from this deal are:

1. This is another example of how important it is to have a timely and credible valuation and then follow it. The investment bankers prepared a valuation, but the agreed upon price fell outside the range of that valuation according to the Commissioner's report.

2. Conflicts can take all different shapes, but they all attract attention. According to the Insurance Commissioner's findings there were potential conflicts for one of the attorneys (who had represented one of the executives), the investment banker (from its percentage fee arrangement), and the directors and officers (who benefited from the bonuses and other compensation that apparently became part of the deal negotiations). The first two conflicts alone likely would not have been a problem with adequate disclosure and an unbiased review of the arrangement, but with the addition of the personal benefits to directors and officers the combination acts as a lightning rod that draws in state regulatory review.

3. It is extremely important to educate the public, including the regulators, on the community benefits of any major nonprofit transaction. That includes examining alternatives and trying to quantify the impact on access to health care and the cost of health care. For nonprofits, that may mean that mission wins out over profits.

4. To paraphrase the real estate folks, for any nonprofit regulatory review, whether from the state or the IRS, it comes down to three things, procedure, procedure, procedure. A fair, equitable and open process for reviewing a transactions and for dealing with potential purchasers goes a long way toward establishing the bona fides of a deal. Cutting side deals or stacking the deck for one party, which is basically what the Commissioner was alleging here, will cause the regulators to challenge those bona fides.

3. Michigan Rules

Michigan has not had a major charitable trust related court battle since then Attorney General Frank Kelly succeeded in blocking a whole hospital joint venture between Columbia/HCA and Michigan Affiliated Healthcare System, Inc. ("MAHSI") in 1996. One of the key arguments in that case was that the nonprofit's directors breached their fiduciary duty by not seeking an IRS private letter ruling on the joint venture. The AG has focused on lack of an IRS ruling in more recent administrative matters involving other nonprofits seeking to convert to for-profit status. Although at this point an IRS ruling is not required by the AG, any nonprofit seeking AG approval of a transaction must be prepared to either seek a ruling or have a reasonable explanation as to why a ruling from the IRS is not necessary or helpful.

In the *MAHSI* case, the AG also made arguments based on charitable trust principles and specific provisions of the Michigan Nonprofit Corporations Act related to the use of charitable assets. The

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primary charitable trust statute, the Michigan Supervision of Trustees for Charitable Purposes Act, does not apply to hospitals (MCLA 14.253). Nevertheless, the AG's office would argue that it has common law charitable trust powers to regulate hospital transactions. Other health care organizations with charitable activities also would be covered by this charitable trust statute. In addition, another statute (the Dissolution of Charitable Purpose Corporations Act, MCLA 450.251 - .253) gives the AG the authority to approve any merger or dissolution of a nonprofit corporation (other than mergers into another nonprofit).

All Michigan nonprofits are subject to the restrictions of the Michigan Nonprofit Corporation Act. Section 261(n) of that Act permits nonprofit corporations to participate in joint ventures for any activity which the participating nonprofit would have authority to conduct on its own, even if the joint venture involves "sharing or delegation of control with or to others." Section 301(5), however, contains a general limitation on the use of charitable assets relied on by the AG in the *MAHSI* case. Under that section, assets held by a nonprofit corporation for charitable purposes may not be used, conveyed or distributed for noncharitable purposes. To date, the *MAHSI* case is the only example of attempted enforcement of Section 301(5) with respect to a health care transaction.

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THE IMPACT OF THE SARBANES-OXLEY ACT OF 2000 ON NONPROFIT ENTITIES

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I. Purpose

The purpose of this outline is to provide an overview of the implications which the Sarbanes-Oxley Act of 2002 (the "SOA") may have with respect to the operation of nonprofit organizations and to provide a basis for understanding state-initiated actions to review the operations of such entities, including actions initiated by state attorneys general. Finally, this outline describes the corporate fiduciary duty obligations which board members owe to nonprofit corporations and the heightened scrutiny likely to be accorded to board determinations in light of the collapse of large, publicly-traded corporations.

II. History of New Focus on Corporate Accountability

Recent federal and state corporate reform measures are the direct result of the accounting and inappropriate management revelations which were discovered to have contributed to the downfall of several multi-national conglomerates including Enron and MCI Worldcom. Indeed, the recent increased emphasis on corporate responsibility and corporate integrity are not the result of a single event or legislative initiative. Rather, these corporate scandals, along with financial demise or rehabilitation of several notable nonprofit health care systems have served to create an environment in which the public is focused upon the ability of corporate managers to conduct the business affairs of corporations in a manner which is fiscally responsible.

While the SOA regulates publicly traded companies, commentators have suggested that its requirements are likely to evolve in such a way as to be applicable to the nonprofit sector. Indeed, the New York Attorney General announced his intention to apply SOA-based reporting requirements upon nonprofit corporations doing business in the state. However, in order to understand the application of SOA to nonprofits, it is important to appreciate that some of the inappropriate financial management issues raised by Enron and MCI Worldcom could also occur in nonprofit corporations. In this regard, the abuses and wrongs which SOA is designed to protect against could occur in a nonprofit context and should therefore be subject to scrutiny.

A. Enron

Outside of the charitable organization context, the most visible and notorious cause of the corporate responsibility environment has been the financial collapse of Enron Corporation. When it declared bankruptcy in 2001, Enron was the seventh largest company in the United States, with over $100 billion in gross revenues and more than 20,000 employees worldwide. While other notable companies have also disintegrated, such as MCI Worldcom, Enron's demise was the first, and therefore most memorable corporate meltdown.

The bankruptcy filing resulted in the loss of thousands of jobs and billions of dollars in equity and prompted investigations by Congress, the Securities and Exchange Commission, and the Department of Justice. Enron's collapse also led to the filing of multiple shareholder lawsuits alleging breach of fiduciary duty, among other claims. Similar to other notable corporate failures, Enron's

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collapse is directly responsible for the current atmosphere of intense scrutiny of corporate financial and accounting operations. It has led to investigations of many major U.S. corporations and the enactment of federal legislation addressing a wide variety of corporate responsibility initiatives. The full impact of the Enron bankruptcy will not be known for years to come as Enron's failure will result in numerous changes in business and financial accountability policy for both nonprofit and for-profit corporations.

Enron's financial collapse was caused in large part by financial restatements related to complex "related party" and "off balance sheet" financial transactions. These were pursued in order to achieve certain financial statement objectives, necessitated by the economic fluctuations of Enron's business. Enron was notable in many respects due to the complexity of the underlying allegations, *e.g*., deception by using corporate transactions to move certain assets off of financial statements and to improperly inflate earnings. The Enron transactions were accomplished through the use of various partnerships and special purpose entities that were designed to diminish Enron's risk on certain investments. These transactions served to conceal Enron's financial losses, thereby resulting in a favorable financial outlook for the entity.

In addition to questionable related party transactions, allegations arose about conflicts of interest and overly aggressive advice from Enron's auditors Arthur Andersen. Andersen billed Enron almost $27 million in consulting fees and $25 million in audit fees. In this regard, Andersen was charge with auditing arrangements established by its consulting arm, thereby resulting in a conflict situation.

The Enron bankruptcy prompted several high profile examinations of the conduct of Enron's Board of Directors during the timeframe in which the suspect transactions occurred. In this regard, internal reports suggested that the Board of Directors of Enron failed in its oversight duties. Critics alleged that the Board underestimated the severity of the conflicts and overestimated the ability of management controls and procedures to address and correct internal abuses. For example, the Board failed to pay attention to the various partnerships Enron entered into with its CFO. The Board failed in its obligations to investigate thoroughly the details of these transactions to insure that they were fair and equitable to Enron. Indeed, periodic reviews by Enron's audit and finance committees were deemed "too superficial" to be of value. These revelations served in large part as the basis for the subsequent enactment of the Sarbanes-Oxley Act of 2002.

An initial internal examination was conducted by the Special Investigative Committee of the Board of Directors of Enron Corporation.[1] Its report (prepared with the assistance of special counsel) contained a detailed self-analysis of the governance actions related to the entire accounting controversy, and reached several important conclusions, including the following:

- Board and management oversight were impaired by conflicts of interest;
- The concept of the related party transactions was flawed;
- Board-adopted controls were inadequate and not appropriately implemented;
- Senior management did not exercise sufficient oversight;

[1] Dated February 2, 2002. Referred to as the "Powers Report," named for the Committee which was chaired by Dean Powers of the University of Texas Law School (and a member of the Enron Board).

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- Senior management did not respond adequately when issues arose that required a vigorous response;
- The Audit and Compliance Committee of the Board carried out its assigned review in a cursory manner;
- The Board was denied important information that might have led it to take action;
- The Board did not appreciate fully the significance of some of the specific information that came before it; and
- The outside auditors did not identify or bring to the Audit Committee's attention the inadequacies in Enron's internal controls.

A subsequent examination of Enron was conducted by the Permanent Subcommittee on Investigations of the Committee on Governmental Affairs, U.S. Senate.[2] The Subcommittee conducted an extensive examination of the Enron matters, reviewed over one million pages of subpoenaed documents, interviewed thirteen Enron Board members, and received testimony from several governance experts. The Subcommittee's conclusions were that:

- The Board failed to safeguard corporate assets and contributed to the corporation's collapse by allowing it to engage in: (1) high risk accounting practices, (2) inappropriate conflict of interest transactions, (3) extensive off-the-books activities, and (4) excessive compensation; and
- The independence of the Enron Board was compromised by financial ties between the company and certain Board members.

The Subcommittee also made several recommendations with respect to how (publicly traded) companies conduct their business affairs. The first recommendation related to the need to strengthen the financial oversight of corporate affairs, while the second related to the need to strengthen the independence of corporate governance. Both were reflected in the final version of the Sarbanes-Oxley Act.

B. AHERF and Allina

Commentators suggested that the effect of the Enron bankruptcy, coupled with the bankruptcy of Allegheny Health, Education and Research Foundation ("AHERF") was a significant factor which lead to an increased interest in extending financial regulatory oversight to nonprofit organizations, including nonprofit health systems. Indeed, there were many similarities between AHERF's financial meltdown and the Enron bankruptcy. In particular, both entities experienced rapid growth and expansion in a short period. Both suffered because of insufficient financial disclosure to creditors and investors. Further, both entities had complex legal structures which enhanced their ability to mask their true financial circumstances. Finally, it has been suggested that both failed due to a lack of financial auditor oversight and disclosure. Interestingly, although not present in the AHERF failure, both Enron and nonprofit health systems have a common practice of using off-balance-sheet financing. For example, holders of tax-exempt bonds may not be privy to the financial statements of the entire health system, since not all members of the health system are part of an obligated group for bond finance purposes. Additionally, in some systems, the organizational structure is such that a financially stable hospital may be caused to

[2] Dated July 8, 2002, entitled "The Role of the Board of Directors in Enron's Collapse."

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finance the operations of a struggling system affiliate. In the same way, Enron hid its true financial status by the use of partnerships and other devices which allowed it to divert significant losses from Enron's financial statements. The AHERF bankruptcy was significant, and provides a somber nexus to the Enron collapse because the SEC charged AHERF executives and the system's outside auditors with securities fraud.

State Attorneys General, often the public agents charged with protecting nonprofit assets, have expressed interest in exercising financial oversight of nonprofits as a result of the Enron bankruptcy. For example, the Minnesota Attorney General required Allina Health System ("Allina") and its related health plan, Medica, to enter into an agreement which restricted their actions and activities through December 2002. The agreement was the result of an 18-month financial audit of Allina and Medica which reportedly found excessive spending by the health system, including allegations that the system failed to properly oversee consultants. According to the Minnesota Attorney General, Medica spent 18.7% of its revenue on administration which was nearly twice as much as it reported to the Minnesota Department of Health. The report alleges that Medica hid administrative expenses, such as claims processing services under healthcare delivery system accounts.[3] In this regard, the reallocation of expenses was thought to have resulted in a false impression with respect to the financial viability of any other affiliated entity.

III. Regulatory and Other Responses to Enron

A. Federal Legislation – Sarbanes-Oxley Act of 2002

The SOA was conceived as a set of legal reforms in response to: (a) the corporate accounting controversies of 2002, (b) the need to protect the interests of investors, and (c) the need to provide stability to financial markets. SOA establishes a new oversight mechanism for the public accounting profession, creates new rules for the auditor/client relationship, and institutes new criminal penalties for corporate finance-related crimes. It also establishes corporate responsibility procedures for executive and board conduct, assigns new ethical obligations to corporate counsel, and provides new protections for investors. SOA applies only to publicly-traded companies.

1. SOA is organized into the following areas:

   1.1 <u>Public Company Accounting Oversight Board</u>: Establishes the Public Company Accounting Oversight Board to oversee the audit of public companies that are subject to the SOA.

   1.2 <u>Auditor Independence</u>: Establishes rules relating to the use and management of audit firms, including rules limiting the use of audit firms for non-audit services; establishes auditor rotation requirements.

   1.3 <u>Corporate Responsibility</u>: Establishes rules for corporate audit committees; corporate responsibility for financial reports; corporate bonus and profit compensation arrangements; insider trading rules; rules making it unlawful to

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[3] *See* Galloro, "Report Grounds Allina: Minnesota puts Restrictions on System, Health Plan," Modern Healthcare (October 1, 2001).

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attempt to manipulate an auditor; and rules for attorneys appearing and practicing before the SEC.

1.4 Enhanced Financial Disclosures: Establishes requirements relating to accurate financial reporting; off-balance sheet reporting; enhanced conflicts of interest provisions; disclosures of transactions involving management, principal stockholders, directors and officers; adoption of a code of ethics for senior financial officers; enhanced review of periodic disclosures; and real-time disclosures.

1.5 Analyst Conflicts of Interest: Establishes rules relating to conflicts of interest that can arise when securities analysts recommend equities securities in research reports.

1.6 Commission Resources and Authority: Establishes funding to carry out functions, powers and duties; authority to censure certain persons from practice before the SEC; and rules addressing the qualifications of brokers and dealers.

1.7 Studies and Reports: Authorizes the undertaking of certain studies and reports.

1.8 Corporate and Criminal Fraud Accountability: Establishes penalties for the destruction or alteration of certain documents; extends statute of limitations for a private right of action involving claims of fraud; establishment of a statute of limitations for the prosecution of such conduct; establishes protections for whistleblowers.

1.9 White Collar Crime Penalty Enhancements: Subjecting violators of the SOA to certain penalties and criminal prosecution.

1.10 Corporate Tax Returns: Relying the sense of the Senate that the CEO should sign Federal income tax returns for a corporation.

1.11 Corporate Fraud and Accountability: Establishes penalties for altering or destroying or concealing corporate records; amendments to Federal Sentencing Guidelines.

2. Summary of Key Concepts

The SOA establishes a number of protocols and reporting requirements upon publicly-traded companies. Further, the SOA outlines requirements for auditor and audit committee independence and requires companies to adhere to strong conflicts of interest policies. The following significant topics are addressed in the SOA:

2.1 Certifications: The CEOs and CFOs of publicly-traded companies must certify periodic reports which are filed with the Securities and Exchange Commission. The

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SOA sets forth the contents of these periodic reports and requires that the officers certify that the report complies with applicable statutory guidelines and fairly presents, in all material respects the financial condition and results of operations.

2.2 Prohibition of Personal Loans to Officers and Directors: SOA prohibits public companies from making personal loans to officers and directors of the company.

2.3 Prohibition of Insider Trading During Pension Fund Blackout Periods: Under SOA, officers and directors are prohibited from purchasing, selling, acquiring or transferring any equity security of a company acquired in connection with his or her service or employment as an officer or director during any blackout period imposed under an employee benefit plan. Further, any profits which an officer or director acquires during any blackout are recoverable regardless of the intent of the officer or director in entering into the transaction.

2.4 Forfeiture of Bonuses and Profit: SOA requires that if a company is required to restate its financial statements due to material noncompliance of the company, as a result of misconduct with respect to financial reporting requirements under the securities laws, the CEO and CFO must reimburse the company for any bonus or other incentive-based or equity-based compensation earned as well as any profits earned during the 12-month period following the filing of the original financial statement.

2.5 Real Time Disclosures: Companies are required to disclose to the public, in plain English and on a "rapid and current" basis, any changes in the financial condition or operation of the company as the SEC may determine is necessary to protect the public.

2.6 Assessment of Internal Controls: Companies will be required to include an internal control report as part of their annual reports. The internal control report must state the responsibility of management for establishing and maintaining an internal control structure as well as an assessment of the effectiveness of such a structure. Accounting firms that prepare or issue audit reports for a company must attest to, and report on, the assessment made by the management of the company.

2.7 Audit Committees: Some of the most important changes which have arisen with respect to the SAO are those changes which relate to audit committees. Some of these changes include: (a) audit committee responsibility for hiring, paying and overseeing accounting firms which must report to the audit committee, and not management; (b) requirement that audit committee be comprised of independent directors of the company (i.e., no member may accept consulting fees or be an affiliated person or subsidiary of the company) and have at least one "financial expert"; and (c) requirement that the audit committee establish procedures to accept and process complaints regarding accounting or auditing matters; (d) establishing authority of audit committees to hire independent counsel.

2.8 Prohibited Auditor Activities: Auditors under SOA are prohibited from providing (contemporaneously with the audit) certain non-audit services, including bookkeeping, design and implementation of financial information systems, appraisal or valuation services or fairness opinions, actuarial services, internal audit outsourcing services,

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management or human resource function services, broker or dealer investment advisor or investment banking services, or legal services.

2.9 Audit Partner Rotation and Auditor Conflicts of Interest: Under SAO, an accounting firm which provides audit services may not provide such services if the lead audit partner has performed audit services for the company for each of the past five years. Further, an auditor of an accounting firm is prohibited from performing an audit for a company if a CEO, controller, CFO or someone serving an equivalent position was employed by the auditing firm and participated in any capacity in the audit of the company during the one year period preceding the date of the initiation of the current audit.

2.10 Protection of Whistleblowers: SOA prohibits the discharging, demotion or harassment of any employee providing information or assistance in investigating possible violation of the SOA rules.

B. Current and Increased Internal Revenue Service Oversight

1. **Private Inurement/ Private Benefit**: The Internal Revenue Code ("IRC" or the "Code") also imposes fiduciary duties upon officers and directors of charitable organizations. While not a recent innovation, these rules take on new meaning in the current regulatory environment. Importantly, in order to maintain exempt status under section 501(c)(3) of the Code, no part of the net earnings of the organization may inure to the benefit of any private shareholder or individual. In addition, section 501(c)(3) requires that charitable organizations be organized and operated exclusively for charitable purposes. Section 1.501(c)(3)-1(c)(2) of the Treasury Regulations states that "[a]n organization is not operated exclusively for one or more exempt purposes if its net earnings inure in whole or in part to the benefit of private shareholders or individuals." The regulations provide that a "private shareholder or individual" is a person having a personal and private interest in the activities of the organization.

In order to satisfy the operational test of the Code an exempt organization must serve a public rather than a private interest. Treas. Reg. § 1.501(c)(3)-1(d)(1)(ii). Clearly, the operation of a nonprofit health care entity will result in serving of some private interest by the exempt organization. For example, an exempt hospital serves the private interests of its physicians and its patients. However, in this instance, the IRS is concerned with the primary purpose of the organization. If the serving of private interests is incidental to the accomplishment of the organization's charitable purposes, and does not represent a substantial non-exempt purpose, the organization's exemption will not be jeopardized.

The IRS has limited the application of the private inurement proscription to "insiders" meaning individuals who have a personal and private interest in the activities of the exempt organization and could thereby cause the organization to expend its assets for private benefit. It is often difficult to determine when the line is crossed that causes an individual to be considered an "insider." The IRS regulations, in explaining the substantial private benefit prohibition, focus on "private interests such as designated individuals, the creator or his family, shareholders of the organization, or persons controlled, directly or indirectly, by such private interests." Additionally, an organization's trustees, officers, members, founders, or substantial contributors may have the requisite relationship to qualify for classification as an insider for purposes of an inurement analysis. The IRS consistently looks to the degree of control which an individual is able to exert over the operations of an exempt entity as the basis for determining an insider relationship. In this regard, and in light of the intermediate sanctions

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regulations and other guidance, it is now clear that an individual must be in a position to substantially influence the affairs of the exempt organization in order to be treated as an insider for private inurement purposes.

Thus, the Code effectively places a fiduciary duty on officers and directors to avoid activities and transactions which would result in private inurement or impermissible private benefit, both for themselves and for the organization. This obligation is consistent with the requirements imposed upon publicly-traded companies under SOA. In both cases, the governing boards and senior managers are responsible for insuring that the assets of their companies are managed in a responsible manner.

It is important to note that the IRC does not prohibit all dealings between a charitable organization and its insiders. Insiders may enter into arm's length transactions with the charitable organization and receive reasonable compensation for goods or services provided to the organization without violating the rule against private inurement.

2. Intermediate Sanctions Prohibitions: Section 4958 was added to the IRC to impose certain excise penalty taxes upon "disqualified persons" who enter into excess benefit transactions with applicable tax-exempt organizations and those "organization managers" who knowingly participate in an excess benefit transaction. Any transaction with a 501(c)(3) or 501(c)(4) organization that is not consistent with fair market value is an excess benefit transaction. Intent is irrelevant in determining whether someone has received an excess benefit. Although the exempt organization is not itself subject to these taxes, the IRS can revoke exemption in certain circumstances for substantial or repeated excess benefit transactions. In its Continuing Professional Education Textbook for 2002, the IRS identified four factors which might impact upon whether or not the IRS would be likely to revoke the tax-exempt status of an organization: (i) repeated excess benefit transactions involving an applicable tax-exempt organization; (ii) the size and scope of the excess benefit transactions; (iii) implementation of safeguards to prevent recurrences; and (4) compliance with other laws.

1. Section 4958 imposes the following taxes:

- All "disqualified persons" who receive an excess benefit are taxed at a rate of 25% of the amount of that excess benefit (i.e., 25% of the difference from fair market value). There is an additional 200% tax if the benefit is not repaid with interest or otherwise corrected. If the transaction is deemed willful and flagrant, the taxes may be doubled under Section 6684. Certain people, such as voting trustees, are automatically disqualified persons for at least five years, even if they leave that position. Generally, for other people and entities, the test is whether they are in a position to exercise substantial influence over the affairs of the 501(c)(3) organization. Being a disqualified person of one entity carries over to related entities, such as from a parent company to a subsidiary company.

- All "organization managers" that knowingly participate in an excess benefit transaction are subject to an excise tax of 10% of the amount of the excess benefit, with the tax capped at $10,000 per transaction. All voting members of the board, among others, are organization managers. These taxes are self-assessing, but the 501(c)(3) organization is obligated to report all such transactions on its Form 990. An organization manager is not liable for the imposition of the tax if he or she had

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reasonable cause to believe that the transaction would not result in an excess benefit transaction.

2. *Rebuttable Presumption as to Reasonableness:* Exempt organizations may take steps to create a rebuttable presumption that particular transactions are reasonable under the intermediate sanctions rules. A presumption that a particular transaction is reasonable may arise if such an arrangement was approved by an authorized body, such as the board of directors, (including any parties authorized to act on behalf of the governing body) that:

- was composed entirely of individuals unrelated to and not subject to the control of the disqualified person(s) involved in the arrangement;
- obtained and relied on appropriate data as to comparability (e.g., compensation levels paid by similarly situated organizations, both taxable and tax-exempt, for functionally comparable positions; the location of the organization, including the availability of similar specialties in the geographic area; independent compensation surveys by nationally recognized independent firms; or actual written offers from similar institutions competing for the services of the disqualified person); and
- adequately documented the basis for its determination (e.g., the record includes an evaluation of the individual whose compensation was being established and the basis for determining that the individual's compensation was reasonable in light of that evaluation data).

A single individual may be the "authorized body" for purposes of establishing the rebuttable presumption of fair market value under applicable regulations if state law allows that authority to be delegated to a single individual.

In this way, the intermediate sanctions guidelines serve as a way to further enhance corporate integrity as it relates to transactions by and between a tax-exempt 501(c)(3) or 501(c)(4) entity and certain parties. Adherence to the rules which allow an entity to establish a rebuttable presumption as to the reasonableness of a transaction serve to document that these transactions are fair to the corporation, a goal of the SOA rules.

3. IRS Conflicts of Interest Policy: The IRS had for many years indicated informally that it believed a conflicts of interest policy to be an important tool for ensuring the prevention of private inurement and impermissible private benefit in tax-exempt healthcare organizations. In its Continuing Professional Education Textbook for 1997, the IRS set forth the terms of a conflicts of interest policy for an exempt organization in order for the organization to obtain or maintain tax-exempt status under the Code. The sample conflicts of interest policy is regarded as a "safe harbor" benchmark for exempt organizations.

In reviewing conflict of interest policies, the IRS has noted that, in lieu of the safe harbor, an organization may show other facts and circumstances that would balance the roles of other interested individuals to ensure that the healthcare organization operates for exclusively public purposes. Thus, the IRS would look for an organization to demonstrate that its governing board is broadly representative of the community and that the majority of the governing board comprises members who are independent of the organization; that the governing board has adopted and implemented a conflicts of interest policy;

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and that all components of the organization conduct periodic activity reviews to ensure that the organization is operating in a charitable manner.

The IRS refers to these facts and circumstances as its "Community Board and Conflicts of Interest Policy." The IRS has noted that a community board is one in which independent persons representative of the community constitute the majority. This is significant, in that it creates a 49% safe harbor, i.e., 49% of the board can be individuals who are not independent of the organization and the policy will still be satisfied. Thus, practicing physicians affiliated with a hospital, officers, department heads, and other employees of the hospital are not independent and may not constitute a majority of the hospital's board. Other persons who may have some business dealings with the healthcare organization are usually included in the majority; however, the entire board of trustees must satisfy the conflicts of interest policy.

In the IRS's view, the primary benefit of the conflicts of interest policy is that the governing board can make its decisions in an objective manner without undue influence by persons with a private interest. Such behavior enhances the corporate integrity of a nonprofit corporation. The IRS has stated that the presence and enforcement of a substantial conflicts of interest policy can also ensure that a tax-exempt healthcare organization will fulfill its charitable purposes, will properly oversee the activities of its governing body and principal officers, and will pay no more than reasonable compensation to physicians or other highly compensated employees.

The IRS will generally apply its Community Board and Conflicts of Interest Policy when it considers applications for recognition of exemption from hospitals or from other healthcare organizations that are part of a multi-entity health system.

Importantly, the IRS will consider historic development and a record of significant charitable operations to determine if an existing exempt healthcare organization requires an independent community board; where there is a long history of substantial community service and an absence of private inurement or impermissible private benefit, the IRS may not require that the community board standard be met in a given case. It appears that this application of the policy will enable entities such as tax-exempt physician clinics that have demonstrated a solid track record of charitable operation for many years, notwithstanding the fact that they have a board comprising more than 49% interested physicians, will be permitted to maintain this type of board composition. The IRS has also stated the converse: if an existing healthcare organization has a record of problems with its charitable operations, or has a history of private inurement or impermissible private benefit, the Service may revert to applying its 20% safe harbor guideline.

The IRS also believes that its Community Board and Conflicts of Interest Policy may be useful as guidance for IRS agents to determine how a tax-exempt organization that is in danger of having its exemption revoked may be rehabilitated. The establishment of a system of periodic reviews called for by the policy is consistent with the current push for governance reform. The IRS believes that such reviews will help to demonstrate that the tax-exempt healthcare organization promotes the health of the community as a whole.

The SOA provisions impose requirements upon publicly-traded companies when it comes to managing conflicts with auditors, consultants, officers and directors, among others. In this regard,

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although nonprofits have been subject to rules requiring the adoption of conflicts of interest policies, the current environment is likely to result in a review of these rules in an effort to enhance conflict disclosures.

4. IRS Form 990 Revisions: The IRS Form 990 is the annual report filed by exempt organizations to report revenues and expenditures for the year. Over the years, the IRS Form 990 has been revised to allow exempt organizations to report information regarding highly compensated employees and service providers. In addition, the IRS Form 990 was revised to allow exempt organizations to furnish information relating to the accomplishment of charitable purposes over the year. In Announcement 2002-87, the IRS requested comments with respect to possible changes to the Form 990 in order to improve both the content and quality of the information contained therein. The request for comments was related directly to a concern that nonprofit corporations could engage in activities which do not allow for the reporting of accurate financial information. With respect to corporate responsibility, the IRS indicated that it was considering whether measures such as the following should be taken:

- Whether exempt organizations should be required to disclose on Form 990 whether they have adopted conflicts of interest policies or have independent audit committees.
- Whether non-charitable exempt organizations should be required to disclose information about transactions with their substantial contributors, officers, directors, trustees, and key employees similar to the disclosures required in Schedule A, Part III, Question 2.
- Whether exempt organizations should be required to disclose on Form 990 any information in addition to that required in Schedule A, Part III, Question 2, officers, directors, trustees and key employees.
- Whether there are any other changes to the Form 990 or other requirements that would increase public confidence in the integrity of exempt organization disclosures.

Clearly, the IRS is interested in insuring that nonprofit corporations do not engage in any fraudulent reporting or any other activities which result in a conflict of interest. Any disclosures pursuant to the above inquiries should be undertaken only after careful consideration. Indeed, the mere adoption of a conflict of interest policy does not mean that such a policy is a satisfactory one. Further, adoption of such a policy does not mean that the organization adhered to the policy requirements in its operations. Also, the failure of a nonprofit corporation to have an audit committee may or may not be poor practice depending upon the size of the organization and the sophistication of its financial operations.

C. State Trends in Oversight and Regulation

1. State Nonprofit Law Implications - State Statutory and Common Law Duties of Officers and Directors

Generally, under state statutory and common law, directors owe a duty of care and a duty of loyalty in discharging their obligations on behalf of a corporation. The ABA's Guidebook for Directors of Nonprofit Corporations has suggested that these duties are the common terms to describe the standards which guide all actions that a director or officer takes on behalf of a corporation.

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Additionally, these duties apply whether the directors serve for-profit or nonprofit corporations due to the fact that the ABA's Revised Model Nonprofit Corporation Act rejects the approach that charities are trusts and directors are trustees that should be held to a high standard. Most nonprofit corporation statutes are modeled on the for profit laws.

When an individual serves an officer or director of several different, but related organizations, it is imperative for him or her to determine to whom his or her fiduciary duty is owed at any particular time. In this regard, an individual must pay attention to which "hat" is being worn at a given time. In addition, nonprofit directors owe a duty to the members of an organization. Such duty is not to maximize profits (as would be the case in a for-profit corporation), but to advance the organization's charitable purposes. It is likely that state authorities will review these rules in order to impose SOA-type requirements upon nonprofit entities.

a. The Duty of Care. The duty of care calls upon a director to participate in the decisions of the board of directors and to be informed as to that information which is relevant to make such decisions. In particular, the duty requires that officers and directors carry out their responsibilities in good faith and with that degree of diligence, care and skill which ordinarily prudent persons would exercise under similar circumstances in like positions. In general this duty requires informed, good faith decisions which are intended to further the organization's charitable purposes. It is important to know that the directors and officers may rely upon information provided by others who the director believes to be reliable and competent in the matters presented. In addition, the duty of care requires that a director be informed and exercise independent judgment. In this regard, directors should regularly attend board meetings in order to make informed decisions. Importantly, an individual director may not delegate his or her responsibilities as a director.

b. The Duty of Loyalty. The duty of loyalty requires directors to exercise their powers in a manner which he or she reasonably believes to be in the best interests of the corporation and not in their own interest or the interest of another entity or person. Directors of nonprofit corporations may have interests in conflict with those of the corporation. The duty of loyalty requires that a director be conscious of the potential for such conflicts and act with candor and care in dealing with such situations. Conflicts of interest involving a director are not inherently illegal nor are they to be regarded as a reflection on the integrity of the board of directors or of any individual director. It is the manner in which the director and the board deal with a disclosed conflict which determines the propriety of the transaction.

A director should be sensitive to any interest he or she may have in a decision to be made by the board of directors and, as far as possible, recognize such interest prior to the discussion or presentation of such a matter before the board. When a director has an interest in a transaction being considered by the board of directors, the director should disclose the conflict before the board of directors takes action on the matter. Upon disclosure by the director, the board should provide a disinterested review of the matter. IRS conflict of interest policy guidelines further dictate that directors not be present for votes involving matters of conflicted interest. They may, however, be available to provide important information to disinterested directors.

c. The Duty of Obedience. Some commentators have suggested that the duty of obedience, a subset of the duty of loyalty, is evolving into a duty of its own and has taken on great

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significance for nonprofit organizations. The duty of obedience requires that nonprofit governing bodies effectively carry out the purposes of the organization. This duty contemplates oversight to insure that the corporation's assets continue to be used for charitable purposes which closely follow those set forth in the organization's charter. In this regard, the duty of obedience relates to a director's obligation to ensure that the mission of the nonprofit is carried out and the organization complies with applicable law.

d. The Business Judgment Rule. In the for-profit environment, the duties established for directors of corporations are usually accompanied by a judicial standard of review that is deferential to directors known as the business judgment rule. There are various formulations of the business judgment rule. However, it is generally a presumption in favor of the appropriateness of director decisions that have been made: (i) in good faith and without a conflict of interest; (ii) on a reasonably informed basis; and (iii) with a rational belief that the business judgment is in the best interests of the corporation. The Model Nonprofit Corporation Act does not require use of the business judgment rule in the evaluation of decisions of nonprofit boards. However, it appears to be the likely standard and has been used by several courts in considering nonprofit board decisions.

2. State Law Implications - State Regulator Oversight and Control

a. Minnesota Attorney General: Minnesota Attorney General Mike Hatch released a report entitled "Corporate Responsibility" in which he outlines proposals for corporate audits and engaging and overseeing auditors for a company. Some of the proposals which Attorney General Hatch outlined in his report were more restrictive than those set forth in the SOA. For example, he recommended a two-year prohibition on hiring senior audit personal by the audited company. In this regard, we can expect other states to initiate rules regarding corporate integrity and responsibility and imposing those rules upon nonprofits with respect to their operations. Some of the recommendations that Attorney General Hatch suggested for the management of nonprofits included the following: (a) adoption of a corporate code of ethics; (b) majority of board members must be outside directors; (c) only outside directors may serve on the audit, compensation and nominations committees; (d) term limits for board members; (e) outside directors should meet without management present; (f) outside directors should meet senior executives without going through the CEO; (g) limitations on the number of boards that directors serve on; and (g) one member of the audit committee should be a "financial expert."

b. New York Attorney General: In January 2003, New York Attorney General Eliot Spitzer proposed reforms designed to strengthen New York's corporate accountability laws. His stated desire was to close the types of loopholes that allowed abuses to go undetected at major corporations and to provide protections against abuses by nonprofit corporations. In this regard, the New York Attorney General noted that the SOA protections only applied to companies listed on a major stock exchange and not to their nonprofit counterparts. In public comments he stated that he was seeking to protect not only investors but charitable donors as well. As a result, New York becomes one of the first states to propose to apply SOA-type reporting requirements to nonprofit corporate activity.

c. Michigan Governor Executive Order: The elected leadership in the State of Michigan appears to have taken an interest in insuring that corporations which do business with the state operate with regard to the highest ethical standards. In her first day in office, Governor Jennifer Granholm signed Executive Order Number 2003-1: Procurement of Goods and Services from Vendors in Compliance with State and Federal Law. The order allows the State to revoke, suspend or prohibit

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contracting privileges with the State of those vendors which (within the past three years) have been convicted of certain criminal offenses, including an offense which negatively reflects on the vendor's business integrity. Consequently, we see other examples in which a State is seeking to regulate the corporate integrity of businesses, whether organized on a for-profit or nonprofit basis.

IV. Implementation Strategies for Heightened Accountability

A. The Application of Specific SOA Rules Nonprofit Corporations

Before an exempt organization can consider implementing any of the SOA provisions to its current operations, it would be helpful to understand exactly which provisions are likely to be broadly applicable to the operations and activities of an exempt organization. The following rules, derived from the SOA, provide a starting point for programs and policies which might be considered by nonprofit organizations in establishing a corporate integrity program. While the SOA provisions are not, by law, imposed upon the activities and operations of nonprofit entities, these guidelines may nonetheless provide a helpful framework within which to establish a program for those organizations choosing to do so:

1. <u>Audit Committee.</u> A dedicated audit committee of the Board should be established to oversee accounting and financial reporting matters and to review the adequacy of internal controls. This committee should give focus to all financial matters, including risks that are particular to such organization. Importantly, such a committee should have at least one person who is a financial expert (i.e., someone with an understanding of GAAP and financial statements). It has been suggested that an audit committee without a financial expert could hire one as a consultant and thereby comply with the spirit of the SOA. [SOA §§ 205, 301 407]

2. <u>Code of Ethics</u>. Public companies must disclose whether their senior financial executives are subject to a code of ethics. Nonprofits should develop such codes to promote honest and ethical conduct, compliance with laws and regulations and full and fair disclosure of information. In this regard, many nonprofits adopted such policies as part of developing corporate compliance programs. Consequently, it is possible that the adoption of such a policy will be unnecessary, but merely an opportunity to revisit and refine an existing policy. [SOA § 406]

3. <u>Corporate Responsibility for Financial Reports.</u> A nonprofit organization should develop an internal process which would facilitate the ability of the principal executive officers of a nonprofit corporation to certify the corporation's periodic financial reports in the event that nonprofit organizations are required to implement certifications standards which are similar to those set for in the SOA. The SOA requires that certain senior managers of public companies certify that the financial statements fairly present the financial conditions of their companies. These executives must review their companies' internal controls and report on their adequacy. Indeed, certifications such as those called for by the SOA are beginning to be requested of nonprofit corporations by third parties such as lenders or underwriters in the normal course of business. [SOA § 302]

4. <u>Annual Reports.</u> Nonprofits are required to file annual reports and to make such reports widely available to the public. Nonprofit corporations should use the annual report as an opportunity to communicate important information to the public about their charitable activities and should consider providing disclosure on governance matters and the procedures being used to ensure that the financial

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condition is understood by the board and management and is transparent to third parties who may review such reports or publications. Such a disclosure can serve to enhance public confidence in the financial disclosures of a company.

5. Auditor Independence. Nonprofits should confirm that their auditors are in compliance with all new professional rules, including those being established by the Public Accounting Oversight Board. These rules include strict independence requirements. The nonprofit organization should consider implementing policies to ensure that non-audit consulting services that cannot be purchased by public companies from their auditors similarly cannot be bought by it from its auditor. [SOA § 201, 202]

6. Retaliation against Whistleblowers. The SOA makes it a crime to retaliate against a "whistleblower" who reports information about the commission of any federal offense. "Retaliation" includes interference with a person's employment:

> "Whoever knowingly, with the intent to retaliate, takes any action harmful to any person, including interference with the lawful employment or livelihood of any person, for providing to a law enforcement officer any truthful information relating to the commission or possible commission of any Federal offense, shall be fined under this title or imprisoned not more than 10 years, or both."
>
> There have been various other laws penalizing retaliators but the SOA raises the stakes by making retaliation a crime. In this regard, the rules function in the same way that health regulatory rules do with respect to the reporting of health care fraud and abuse. [SOA § 806]

7. Destruction of Records. The SOA creates a new federal crime for the destruction or alteration of records during a federal investigation. Its application is not limited to for profits. However, some nonprofits such as healthcare institutions are already subject to federal laws that penalize the destruction of records. Adoption of such a rule therefore, would not be unusual for a nonprofit health care entity. [SOA § 802]

8. Loans to Executives. The SOA prohibits personal loans or other extensions of credit to directors and executive officers. This could be difficult for some nonprofits that use mortgage loans or guarantees or similar "perquisites" as part of compensation to induce executives to relocate and join organizations. Indeed, the IRS has provided guidance which describes when such programs are appropriate. Consequently, charities may want to revisit these policies to ensure compliance with current IRS standards. [SOA § 304]

9. Executive Compensation. Nonprofit organizations are accustomed to the strict scrutiny under which their compensation arrangements are reviewed. Consequently, while it is likely that executive compensation arrangements will likely be subject to strict scrutiny in the times ahead, nonprofit corporations should be well-versed in the applicable rules regarding the documentation of the reasonableness of compensation. Boards of nonprofits should review their compensation systems in order to determine whether they are reasonable, provide appropriate and adequate documentation and are sufficiently transparent to all constituencies and regulatory bodies. [SOA § 304]

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B. What You Can Do Now - Pro-Active Steps to Take

1. Conflicts of Interest Policy: An exempt organization should review its current conflicts of interest policy to determine whether it is appropriate and likely to assist the governing board in isolating potential conflicts of interest and managing such conflicts through to resolution. The governing board of the organization should make sure that there are conflict statements completed with respect to each director.

2. Audit Committee: The SOA required publicly traded companies to establish independent audit committees. Importantly, under the SOA corporate auditors are directed to report to these committees and not senior management of the public company. Further, the SOA establishes composition requirements for audit committees which dictate that at least one member of an audit committee be a financial expert (i.e., someone with an understanding of GAAP and financial statements). Nonprofit organizations are likely to experience increased scrutiny over their financial statements. In this regard, the presence of a strong audit committee might prove beneficial to nonprofit organizations, particularly when responding to inquiries from creditors, including bond holders.

3. Assess Risk Exposure: In the current environment, insurers will be seeking to limit their exposure for breaches in the fiduciary duties which directors owe to a corporation. In this regard, nonprofits should review their current D&O liability policies to ascertain the requirements for coverage. In light of recent controversies it is likely that corporations will experience close scrutiny of their operations for underwriting purposes. Policy caps will likely be adjusted with an increase in exposure risks for companies. Implementation of strong financial accountability and conflict of interest policies may well be required of companies by insurers.

4. Corporate Integrity Policy Program: Exempt organizations might consider developing corporate integrity programs which would serve as evidence of an intent to report and disclose accurate financial information. A corporate integrity program could be developed with reference to an existing corporate compliance program. In this regard, many of the general policy directives typically found in a corporate compliance program

- Governance Policy. A corporate integrity policy should include an overarching summary of an individual trustee's or director's primary areas of responsibility.

- Enhanced Conflicts of Interest Policy. The presence of a substantial conflicts of interest policy has been an important variable in considering whether a tax-exempt organization operates in a manner which is consistent with exempt status. Critics have suggested that current IRS policies may not encompass enough guidance to apply to many aspects of the operations of an exempt organization.

- Corporate Opportunity Policy. This policy defines proper board action when an appropriation issue arises and provides guidance to the board on how best to identify system opportunities and to document when the system affirmatively chooses to forgo an opportunity.

- Confidentiality Policy. A clear and substantial *Confidentiality Policy* underscores a director's fundamental duty to maintain the confidentiality of board actions as well as all other information

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regarding the corporation's activities until they are disclosed to the public by the corporation or are otherwise in the public domain.

- Outside Board Service Policy. An *Outside Board Service Policy* sets forth the board's position on concurrent board service by directors and senior managers.

- Oversight Policy. An *Oversight of Senior Management Policy* memorializes the fundamental basic board obligation to serve as the ultimate responsible party for the overall operations of an entity.

- Board Compensation and Indemnification Policy. If a nonprofit corporation chooses to pay and/or indemnify its directors, it should create a specific policy on *Board Compensation and Indemnification* which includes the rationale for compensation and indemnification, explains how directors are to be paid or indemnified, establishes limitations on total compensation, and identifies how compensation and indemnification decisions will be approved by a disinterested body.

- Investment Management Policy. An *Investment Management Policy* sets forth the basic guidelines that the board should consider as it invests the organization's assets through its investment committee and financial advisors.

- Corporate Audit Policy. A policy that sets forth the organization's commitment to *Maintaining the Independence of the Corporate Audit* establishes board protocol for evaluating independent audit firms and specifies when the board or management may engage its audit firm (or an affiliate) to perform non-audit services.

- Management Disclosure Policy. A policy on *Management's Duty to Disclose and Report* responds to the deficiencies in the board/management relationship identified in the Powers Report regarding Enron. This policy identifies the specific situations in which a board would expect that senior management would disclose matters to the board and seek its approval before proceeding.

5. Interface With Other Corporate Compliance Policies: It is likely that a nonprofit health care system has adopted, as have many other health care systems, a corporate compliance program. Such a program is designed to encourage the monitoring, reporting and correction of activities which may be violative Federal anti-kickback and self-referral laws. In particular, such programs typically have two parts: (1) policies and procedures applicable to all employees; and (2) corporate compliance procedures which may be applicable to specific departments or employees.

A corporate integrity program policy should be developed in a way which complements any existing compliance program policy. Consistent policy directives will reduce duplication and costs and result in a more effective implementation of both policies. In this regard, while existing compliance program policies are appropriate for a corporate integrity policy and may be used with minor revisions, if any, others may only serve to provide a helpful template for developing an appropriate corporate integrity policy. Existing compliance program policies which may integrate well with a corporate integrity program include the following:

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- Corporate Policy on Code of Conduct
- Corporate Policy on Duties of Compliance Officers (Chief Integrity Officer)
- Corporate Policy on Training Policies and Procedures
- Corporate Policy on Reporting of Potential Issues or Areas of Noncompliance
- Corporate Policy on Federal and State Government Agency Audits, Interviews, Searches and Other Contacts with the Corporation
- Corporate Policy on Records Management

V. Conclusion

Nonprofit organizations would do well to review existing policies and procedures regarding the disclosure of financially significant information to the public. Additionally, nonprofit organizations should develop policies which increase the likelihood that conflict of interest situations are disclosed to the governing board and other key decision-makers. In developing policies which allow the organization to identify any conflicts of interest which might arise with respect to the operation of the entity, the nonprofit will also work to manage its risk exposure in the governance of such entities. Importantly, such policies will serve to enhance the likelihood of discovering financial or other conflicts which might arise in the operation of the organizations. Further, nonprofit organizations must create a culture in which people are encouraged to report accurate financial information and correct inaccuracies which might arise.

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Sample Hospital Audit Committee
Bylaw Provision

I. Article Audit Committee

1. Purpose

The purpose of the audit committee is to assist the board of directors in fulfilling its oversight responsibilities for the financial reporting process, the system of internal control over financial reporting, the audit process, and the hospital's process for monitoring compliance with financial reporting laws and regulations and the code of conduct.

2. Authority

A. The audit committee will be directly responsible for the appointment, compensation, and oversight of the work of any registered public accounting firm employed by the hospital for the purpose of preparing an audit report and related work. The auditor shall report directly to the audit committee. The audit committee will be responsible for resolving any disagreements between management and the auditor regarding financial reporting.

B. The audit committee shall have the authority to engage independent counsel and have any other advisers it determines necessary to carry out its duties and shall have appropriate funding as determined by the audit committee, in its capacity as a committee of the board of directors for the payment of compensation to the auditors and any other advisors retained by the audit committee.

3. Composition

Each committee member will be independent. For this purpose, a member of the audit committee shall be considered independent if the member does not accept any consulting, advisory, or any other compensation or fee from the hospital, other than as a member of the board or this committee. At least one member shall have expertise in financial reporting.

4. Responsibilities

The committee shall have the following responsibilities:

A. Financial Statements

(1) Review significant accounting and reporting issues, including complex or unusual transactions and highly judgmental areas, and recent professional and regulatory pronouncements, and understand their impact on the financial statements.

(2) Review with management and the external auditors the results of the audit, including any difficulties encountered.

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(3) Review the annual financial statements, and consider whether they are complete, consistent with information known to committee members, and reflect appropriate accounting principles.

(4) Review other sections of the annual report and related regulatory filings before release and consider the accuracy and completeness of the information.

(5) Review with management and the external auditors all matters required to be communicated to the committee under generally accepted auditing standards.

(6) Understand how management develops interim financial information, and the nature and extent of internal and external auditor involvement.

(7) Review interim financial reports with management and the external auditors, before filing with regulators, and consider whether they are complete and consistent with the information known to committee members.

B. Internal Control

(1) Consider the effectiveness of the hospital's internal control over annual and interim financial reporting, including information technology security and control.

(2) Understand the scope of internal and external auditors' review of internal control over financial reporting, and obtain reports on significant findings and recommendations, with management's responses.

C. Internal Audit

(1) Review the effectiveness of the internal audit function, including compliance with The Institute of Internal Auditors' *Standards for the Professional Practice of Internal Auditing*.

(2) On a regular basis, meet separately with the director of internal audit to discuss any matters that the committee or internal audit believes should be discussed privately.

D. Appointment of Auditor

(1) Review and confirm the independence of the external auditors by obtaining statements from the auditors on relationships between the auditors and the hospital, including nonaudit services, and discussing the relationships with the auditors.

(2) Insure that auditor does not provide contemporaneously with audit any nonaudit services regarding financial information, system design or implementation, internal audit services, valuations, appraisals, human resources, and other services.

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E. Complaints

(1) The audit committee shall establish a procedure for the receipt, retention, and treatment of complaints received by the hospital regarding accounting, internal accounting, contracts, or auditing matters.

(2) Receive and address confidential anonymous submissions by employees of the hospital regarding questionable accounting or auditing matters.

F. Reporting Responsibilities

Regularly report to the board of directors about committee activities, issues, and related recommendations.

5. Section Meetings

The committee will meet at least _____________ times a year, with authority to convene additional meetings, as circumstances require. All committee members are expected to attend each meeting, in person or via tele- or video-conference. The committee will invite members of management, auditors, or others to attend meetings and provide pertinent information, as necessary. It will hold private meetings with auditors and executive sessions as determined in its sole discretion. Meeting agendas will be prepared and provided in advance to members, along with appropriate briefing materials. Minutes will be prepared and shall be reviewed, modified or revised as necessary and approved within sixty (60) days of the meeting to which they pertain.

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