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Article

***465** JUXTAPOSING SARBANES-OXLEY WITH JCAHO GOVERNANCE STANDARDS: A SHORTCUT TO AUDITABLE HEALTH SYSTEM COMPLIANCE?[Michael J. Myers](#) [FNd1]

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I. INTRODUCTION

Nonprofit hospitals and healthcare systems have long operated as de facto private clubs. [FN1] They have no "owners," and therefore are not accountable to investors. They are "private," and therefore not accountable to an electorate. [FN2] They freelance in a quasi-public-quasi-private legal cocoon, often for the benefit of physicians, executives, and, yes--the focus of this article--board members sated in conflicts of interest. [FN3]

This phenomenon is embodied in two business models that are predominant among nonprofit hospital systems. [FN4] The first is the "physician cooperative" model, in which the hospital system is operated primarily for the benefit of the system's participating physicians. [FN5] The second is the "polycorporate enterprise," in which the hospital system is operated primarily for the benefit of system executives. [FN6] In the current environment, in which two or three hospital systems typically enjoy oligopolistic market power in a region, physicians, executives, board members, and their aligned business interests are able to place private interests ahead of their presumed public interest without significant risk of detection or penalty. These modern, multi-billion-dollar health systems earn ***466** revenues in amounts sufficient to accommodate their collective interests, attracting an array of entrepreneurial constituents because, to quote bank robber Willie Sutton, that is "where the money is." [FN7]

Lawyers and business consultants play an important role in delivering portions of the nonprofit largesse to those who reside within the system's inner circle. For example, in order to seize market opportunities without jeopardizing their 501(c)(3) tax exemption, systems generally employ the parent holding company structure to segregate and accommodate both nonprofit and for-profit subsidiaries. [FN8] These nonprofit-for-profit business models are considered by some economists to be organizational anomalies, characterized as "bottomless recepta[c]les into which limitless funds can be poured." [FN9] The receptacles are bottomless, in part, because of conflicts between the stated missions of hospital systems and their actual performance in the market. [FN10]

America's hospitals employ 4.7 million people and earn revenues totaling nearly a half trillion dollars. [FN11] This impressive intake of monies is accomplished within a hospital pricing system considered to be increasingly precarious. [FN12] "Over the past twenty-five years, the average ratio of hospital charges for services (gross revenues) to payments received (net revenues) has grown from 1.1 to 2.6. This reflects a transition from predominantly cost- and charge-based payment systems to regulated and negotiated fixed payments." [FN13] It is worth noting that in markets where systems have implemented vertically-integrated health plans, providers in effect negotiate payments with themselves. In those markets, hospitals and physicians perform both as caregivers and insurance companies, an anomalous duality that begs for greater public policy scrutiny than so far received. [FN14] Hospitals responded to payer consolidation by marking up billed charges faster than the cost of providing care, ultimately leading to dozens of lawsuits filed nationwide in 2005 contending that hospital chargemaster-imposed pricing upon the uninsured is excessive and not ***467** commercially reasonable. [FN15]

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Such pricing resides within the core of a healthcare system in the throes of classic market failure, costing \$5,267 per capita at last count and absorbing 14.6 percent of the U.S. gross domestic product. [\[FN16\]](#) The U.S. is expected to spend more than \$2.1 trillion on healthcare in 2006, and reaching \$3 trillion by 2011, [\[FN17\]](#) a level considered to be "unsustainable" in a globally competitive economy. [\[FN18\]](#) Observers and analysts quarrel over the causes of such intractable inflation. Various, they blame "prices, technology, aging, waste, inefficiency, the legal system, new disease patterns, corporate consolidation, or profligate providers and consumers." [\[FN19\]](#) Admittedly, each of these market conditions is a contributor to the cost crises. However, while it is not my desire to join the cacophony of health system critics, I believe the prevailing model of nonprofit governance sanctioned by the Joint Commission for Accreditation of Healthcare Organizations (JCAHO) is incompatible with stakeholder accountability. [\[FN20\]](#) Its design is void of personal and collective risk, an element essential to responsible leadership.

Accordingly, I propose that key requirements of the Sarbanes-Oxley Act (Sarbanes) be incorporated into JCAHO governance standards. Also, I suggest that JCAHO adopt relevant recommendations contained in the 2005 Final Report by the Panel on the Nonprofit Sector to Congress (Panel), established for the purpose of strengthening transparency, governance and accountability of charitable organizations. [\[FN21\]](#) JCAHO governance standards have a long history. They are part of an accreditation process engrained in the bylaws and policies of most nonprofit health systems, hospitals, and affiliated clinics. As a result, they are capable of accommodating the relevant specifications of Sarbanes.

This assertion is made amidst mixed reviews from commentators regarding *468 nonprofit enforcement. [\[FN22\]](#) One concern has been the fear of attorney general activism and the potential for political mischief if Sarbanes restraints are placed upon the nonprofit sector. [\[FN23\]](#) I contend that our proposal is responsive to concerns regarding attorney general activism, or alternatively, attorney general passiveness. Further, by incorporating Sarbanes-type requisites into JCAHO standards, two levels of enhanced accountability would be realized: 1) private, professional review, with its attendant education and self-enforcement and 2) public, external review with the force of the government's police power. This dual level of professional and public oversight would greatly enhance the potential for comprehensive nonprofit accountability. [\[FN24\]](#) A review of the literature suggests that my proposal stands alone in offering this public-private solution.

Since nonprofit health systems have no investors, they issue no public earnings reports. Their financial statements are largely restricted to internal reporting and tax-exempt official statement compliance; hence, they remain irrelevant to the public at large. It is, therefore, understandable that health system leaders recoil at the suggestion they invest hundreds of millions of dollars in information systems designed to detect deficiencies within their own organizations. However, I believe such resistance reflects an underestimation of the changes that await the U.S. health system. I see a federal strategy intended to eliminate fee-for-service from Medicare and Medicaid reimbursement.

II. CEO BOARD SELECTION AND JOB SECURITY

Health system CEO positions are financially and egoistically rewarding. [\[FN25\]](#) Legions of managers aspire for that key box on the organizational chart. Once there, however, a CEO can be expected to employ strategies intended to protect his/her acquired status and associated prerequisites. [\[FN26\]](#) In fact, healthcare *469 administration students are taught that CEO tenure is best protected by first influencing the selection of board members, and second, to the extent legally and ethically permissible, creating director-organizational relationships that reward board members who support the status quo and its current leadership. [\[FN27\]](#)

CEOs do this in a number of ways. Large vertically- and horizontally-integrated health systems, with their various boards, are often structured to hobble pivotal physician and community leaders by the use of designed conflicts of interest. [\[FN28\]](#) Clinically-discrete subsidiaries are commonly led by well-compensated physicians, performing

both clinical and administrative duties, who often have direct or indirect reporting relationships with the CEO. Employed physicians and lay persons with business ties to the system are often appointed to the governing board, which creates and protects interests not identified on the system's organizational chart. [\[FN29\]](#) Further, it is reassuring for a CEO to occupy a boardroom with directors who stand to gain financially from the organization they govern--and even more reassuring at performance appraisal time.

The ability of senior executives to steer business to board members, or their firms, reverses normal governance-management authority and accountability. Board members who gain financially from their governance of nonprofit hospitals are subject to the vulnerabilities described in a recent Deloitte survey. [\[FN30\]](#) The survey was conducted in response to "the recent series of corporate crises around the world" and the 2002 enactment of Sarbanes legislation. [\[FN31\]](#) The survey identified 10 threats to compliance with the Sarbanes-Oxley Act:

- (1) Lack of an enterprise-wide, executive-driven internal control management program,
- (2) Lack of a formal enterprise risk management program,
- (3) Inadequate controls associated with the recording of non-routine, complex, and unusual transactions
- (4) Ineffectively controlled post-merger integration,
- (5) Lack of effective controls over the IT environment,
- (6) Ineffective financial reporting and disclosure preparation processes,
- (7) Lack of formal controls over the financial closing process,
- (8) Lack of current, consistent, complete, and documented accounting policies and procedures,
- (9) Inability to evaluate and test controls over outsourced processes, and
- (10) Inadequate board and audit committee *470 understanding of risk and control. [\[FN32\]](#)

The purpose of the Sarbanes-Oxley Act was to strengthen corporate accountability to investors and the public-at-large in the wake of governance failings related to Enron, Global Crossing, and WorldCom. [\[FN33\]](#) While it is not applicable to nonprofits, a number of nonprofits see Sarbanes as a template for strengthening their governance because of organizational and personal risks related to the web of contractual relationships with Medicare, Medicaid, state regulators, public and private grants, physicians, affiliated providers, and a host of third-party payers. [\[FN34\]](#) Further, the Justice Department's criminal indictment (albeit unsuccessful) and subsequent civil lawsuit against Richard Scrushy of HealthSouth, and allegations of improprieties involving Health MidWest and Allina Health System, have alerted nonprofit CEOs and their boards to an awareness that their "private club" status is at peril. [\[FN35\]](#) The Health Law Reporter has also cautioned the provider bar not to become complacent because of the Scrushy acquittal and an early settlement of a nationwide class action against Tenet Healthcare regarding prices charged the uninsured and underinsured. [\[FN36\]](#) It also pointed to the aggressiveness of the Minnesota Attorney General in forcing sixty hospitals to lower their prices and adopt standards for collection practices as evidence that an era of greater accountability has arrived. [\[FN37\]](#)

As further evidence of a desire for increased accountability, a number of states are enacting laws compelling all hospitals, including nonprofits, to publicize their prices. [\[FN38\]](#) Momentum is also building across the country in favor of requiring hospitals to disclose their infections rates and the methods used to keep hospital-acquired infections in check. [\[FN39\]](#) In addition, [section 4958 of the Internal Revenue Code](#) imposes excise tax liabilities upon CEOs, CFOs, and board members who pay "excess benefits" to executives, physicians, and others. [\[FN40\]](#) The growing risk of personal tax liability is another one of several compelling reasons why the nonprofit healthcare sector should consider adopting *471 key elements of Sarbanes.

Such initiatives and reforms are part of an increased recognition that nonprofit hospitals and healthcare systems are profit-maximizing enterprises providing culturally-favored services. As a result, I suggest that Sarbanes requirements be directed at the nerve center of organizational operations: the system's governing body, its composition, and the manner by which directors become directors, including the prior disclosure of existing and potential direct and indirect business ties to the organization they are asked to govern. Independent audits with state-of-the-art information technology would instill greater stakeholder accountability into the organization and provide board members with information concerning business practices that might place the organization at risk.

I further propose that an optimal method for achieving this reform is for Congress to mandate that key Sarbanes requirements be met as a condition of the deemed status awarded to health care providers by JCAHO, designated by Congress in 1965 to be Medicare's watchdog over hospitals providing care to beneficiaries. [FN41] Now, forty years later, JCAHO is "one of the nation's most influential health groups, evaluating thousands of medical facilities" [FN42] and in a good position to achieve this reform. Further, mandating JCAHO to incorporate the spirit of Sarbanes into its governance standards would also blunt an enduring characterization of the organization as being a "fox-in-the-chicken-coop" protector of physician and hospital market interests. [FN43]

In 1985 the Utah Supreme Court took special note of health care provider insularity when it affirmed a county tax commission decision denying property tax exemption to a hospital owned and operated by the nonprofit, Mormon Church-affiliated Intermountain Health Care Corporation. [FN44] The court's review of the literature disclosed two models that describe how a large number of nonprofit hospitals function: 1) the "physicians' cooperative" model "that operate[s] primarily for the benefit of [the] participating physicians," and 2) the "polycorporate enterprise model"--prevalent among nonprofit hospital chains--where power is largely in the hands of healthcare executives, rather than *472 physicians. [FN45] It was of "considerable significance," said the court, that there is "increasing irrelevance of the distinction between nonprofit and for-profit hospitals[.]" [FN46]

Twenty years have passed since the Utah court criticized these self-serving models of hospital governance and management. During that time the tax-exempt hospital industry has undergone sweeping integration, converting community-controlled, professionally-led hospitals and clinics into "operating units" of multi-billion-dollar companies. [FN47] Commentators far and wide have reached a consensus: the U.S. healthcare system is broken, its wheels have come off, it is unaffordable, and it must be brought under control. As one Oregon physician states, "[o]ur healthcare system is broken, and almost every day, the consequences tear at my heart as a family physician." [FN48] "Bruised and Broken: U.S. Health System," headlines the AARP Bulletin. [FN49] A cursory review of the lay media yields literally hundreds of pronouncements about the broken system, underscoring a physician's sentiment:

And then I get angry at a system that has corrupted the ideals of an honored profession with the uncaring calculations of business. I get angry with the politicians who value the profits of health-care businesses more than the health of your parents. I am embarrassed to work in a health-care system that costs so much yet produces so poorly. [FN50]

To what extent does the system's brokenness reside within the structure of nonprofit hospitals-turned-healthcare systems? To what extent would the regulatory discipline of Sarbanes repair a receptacle into which limitless resources are being poured? To what extent would the governance changes proposed herein enhance accountability on the part of the oligopolistic healthcare systems that have emerged across this nation over the past two decades? The answer, in part, resides with the nonprofit systems themselves. [FN51]

There is, however, growing outside pressure. "Some state attorneys general are considering legislative initiatives that would require not-for-profit" hospitals of sufficient size to adopt some of the Sarbanes requirements. [FN52] The U.S. Department of the Treasury is reported to be considering a rule that would require officers of nonprofits to certify financial statements submitted to the *473 Internal Revenue Service each year. [FN53] At least twenty-five states adopted legislation extending some Sarbanes standards to all public and private corporations in their states. [FN54] Thus, if Sarbanes is considered an evolving template for nonprofit hospital systems, then might that template be best and most efficiently implemented through the accrediting process of the Joint Commission?

III. JCAHO STANDARDS

JCAHO accredits more than 15,000 nonprofit healthcare organizations. [FN55] To obtain JCAHO accreditation, organizations must go through an extensive on-site visit by a team of Joint Commission professionals at the time of initial accreditation and at least once every three years. [FN56] "The Centers for Medicare and Medicaid Services

(CMS) has set 2007 as the date for which all providers must be accredited." [\[FN57\]](#) Accreditation is also a condition of participation in the Medicare and Medicaid programs and essential in order to compete for contracts from larger third-party payers. [\[FN58\]](#)

The Joint Commission's governance standards address the spirit, but not the substance of Sarbanes. They are written in broad, almost symbolic, language. The first standard is open-ended and states: "[t]he organization identifies its governance structure and those responsible for governing the organization." [\[FN59\]](#) Prior to the formation of healthcare systems as we have come to know them today, hospital boards typically were composed of community leaders-- usually twelve to sixteen in number--who could be confronted directly by local residents and taxpayers. JCAHO standards, since 1994, have integrated governance and management responsibilities into a "leadership" category. [\[FN60\]](#) However, it acknowledges that "some governance tasks are different from other management functions[,] . . . [and] these structures and activities cannot be performed well without the cooperation of and coordination with all defined organizational leaders." [\[FN61\]](#)

The crucial place for the application of Sarbanes to JCAHO accreditation is found in the first standard of the JCAHO governance section, which states: "The organization identifies its governance structure and those responsible for governing the organization." [\[FN62\]](#) It provides that "[t]hose responsible for governance establish policy, promote performance improvement, and provide for *474 organizational management and planning." [\[FN63\]](#) These management and planning responsibilities contain the ground most fertile for board members to advance their own interests and the interests of their affiliated organizations and economic allies.

Admittedly, there is an absence of research substantiating the misuse of governance power to benefit private interests. However, this author relies heavily upon his own experience in board selection, participation, and continued board facilitation as the factual backdrop for the proposals contained in this article. [\[FN64\]](#) Nonprofit hospital and health system leadership craft their own rules of conduct by adopting bylaws in accordance with its legal accountability and its responsibility to the patient population served." [\[FN65\]](#) And, overwhelmingly, boards delegate such responsibility by "establishing processes and identifying criteria for selecting a competent and qualified chief executive officer." [\[FN66\]](#) Once selected, competence is measured by tenure: the capacity to retain the CEO position both in times of organizational prosperity and crisis. As mentioned earlier, tenure is best protected by the deliberate creation of conflicts of interest among board members and medical staff leadership. [\[FN67\]](#) However, this understanding often contradicts the ideals articulated in mission statements and statements of corporate philosophy. As stated in one article:

When the personal or professional concerns of a board member or a staff member affect his or her ability to put the welfare of the organization before personal benefit, conflicts of interest exists. Nonprofit board members are likely to be affiliated with many organizations in their communities, both on a professional and personal basis, so it is not unusual for actual or potential conflicts of interest to arise. [\[FN68\]](#) I contend that board service in the nonprofit sector carries with it important ethical obligations and is intended to serve the broad public good. "When board members fail to exercise reasonable care in their oversight of the organization they are not living up to their public trust." [\[FN69\]](#)

One article recommends the adoption of a conflict-of-interest policy that addresses three essential elements: (1) full disclosure, (2) "board member abstention from discussion and voting," and (3) "staff member abstention from decision-making." [\[FN70\]](#) In practice, this "disclosure-only" rule promotes, accommodates, and facilitates an intra-corporate market of private, special-interest trading among executives, board members, and executives. Personal *475 relationships and the promise of future trades predictably, and understandably, trump the broader and effusive public interest. As a result, the best and most effective prophylactic against conflict of interest is applied preemptively, as a barrier against conflicted board membership. A board policy should contain a prohibition against board membership by any person who directly conducts business with the organization or has an affiliation with an organ-

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ization that has in the past or is likely in the future to do business with the organization. In the event such business is conducted, board membership is forfeited.

IV. SARBANES AND INTERNAL CONTROLS

The absence of accountability by nonprofit systems is related to the public's antipathy toward government-controlled healthcare, coupled with a misplaced belief that corporate oligopolies are more trustworthy than government bureaucracies. While such sentiment may be popular, the corporate scandals of 2001 and 2002 demonstrate that managers and directors may not always subordinate their self-interest to the interests of shareholders. The failure of corporate governance is cited as a major cause of the deception that resulted in widespread financial harm to investors and employees alike. [\[FN71\]](#) As stated by one author:

Corporations are failing, employees are being laid off, pension funds are evaporating, and executives are heading to jail. In the wake of this new round of corporate scandals, the government again vainly attempts to prevent individuals from wrongdoing by passing more stringent legislation. While dollar-hungry managers suck the life out of our corporations, the government reaches for that representative wooden stake to kill the vampires taking refuge within these entities. The latest weapon is the Sarbanes-Oxley Act of 2002. [\[FN72\]](#)

Sarbanes requires that audit committees must consist solely of independent directors. Since nonprofit hospital systems have neither stockholders nor shareholders, one might infer that board members are presumptively independent. While beyond the research scope of this paper, it is suggested that a transactional audit of the thousands of transactions that intersect health system organizations would reveal inefficiencies and waste attributable to private interests. [\[FN73\]](#) An example of such waste was successfully prosecuted in the western district of Michigan wherein the U.S. Attorney entered into an innovative settlement with United Memorial Healthcare Association (UMH). The hospital pled guilty to mail fraud in connection with the submission of fraudulent bills by one of its physicians, who was convicted of performing medically unnecessary procedures. [\[FN74\]](#) The settlement required that UMH affiliate with another healthcare entity, leading to its sale to Spectrum Health. [\[FN75\]](#)

***476** Sarbanes requires chief executive officers and chief finance officers to "certify that financial statements fairly present the financial condition and results of their company." [\[FN76\]](#) The Centers for Medicare and Medicaid Services has preempted JCAHO in this regard. Medicare and Medicaid cost reports require certification by CEOs as part of a hospital's Medicare participation agreement. Nonprofit hospital systems would be more directly affected by the Sarbanes provision requiring that outside auditors "attest to and report on management's evaluation of the strength of the company's system of internal control." [\[FN77\]](#)

Sarbanes's prohibition against making loans to executive officers or directors would have little impact on nonprofit hospitals. Lending within the nonprofit hospital sector is restricted almost exclusively to physician recruitment and retention, an area governed by federal anti-kickback safe harbor regulations. [\[FN78\]](#)

The nonprofit hospital sector, as previously noted in the Intermountain decision, behaves much like its proprietary counterpart. Auditors should not be relied upon. [\[FN79\]](#) Nor are lawyers to be trusted. [\[FN80\]](#) It may all be part of a broader fraud culture, as observed by U.S. Congressman Tom Osborne, who stated:

We've seen a bit of a crisis of morals at all levels of society. We've seen it in politics, the business world and the church. I think a very big thing is 20 or 30 years ago when a player did something wrong, he knew it was wrong. There's been a shift in values. [\[FN81\]](#)

The erosion of values in healthcare is addressed in a recent Health Affairs editorial that sets the tone for an assessment of an environment where integrated health systems engage integrated payers within the backdrop of the monopsony power of Medicare and Medicaid. [\[FN82\]](#) The journal also addresses the emergence of physician-owned specialty hospitals through three articles asking 1) whether specialty hospitals are a problem or a symptom, [\[FN83\]](#)

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2) whether specialty hospitals confer greater community benefit than community hospitals, [\[FN84\]](#) and 3) whether physician-owned cardiac hospitals increase utilization. [\[FN85\]](#) Physician-owned specialty hospitals--particularly in South Dakota where the absence of certificate-of-need restraints has earned the state the reputation as a specialty hospital haven--are conspicuous illustrations of professional conflicts of interest.

Conflicts within and outside the boardrooms of healthcare systems should *477 be tested within Joel Demski's contention that "[a] conflict of interest arises when an executive, an officeholder[,] or even an organization encounters a situation where official action or influence has the potential to benefit private interest." [\[FN86\]](#) He offers his examples, which include a physician with a financial interest in a diagnostic laboratory, a congressman whose spouse is a lobbyist or corporate director, or a professor with a financial interest in a particular textbook. [\[FN87\]](#)

The author confronted such a conflict while he was CEO of a 980-bed urban hospital. The physician leader of a major orthopedic group informed a board member that his group was threatening to quit performing surgery at our hospital because of concerns about the quality of care. The system's law firm created a shell "institute," the stated purpose of which was to advance research, education, and clinical information related to the treatment of joint disease. A hospital room was converted to an office, signage applied, and the lead orthopedist designated the institute's president and medical director. He was then compensated with an amount sufficient to reverse the medical group's negative views regarding our quality of care. [\[FN88\]](#) An audit with Sarbanes-level integrity may have detected such an obvious money laundering transaction.

V. CONCLUSION

Statutes, regulations, institutional policy, and audits are limited in their capacity to prevent fraud. Nevertheless, codification remains the tool of choice in addressing conflicts. Carol Bruch reminds us that codification of conflicts law is a reality in much of the world, noting that "[n]ow, for the first time in living memory, an American state [Louisiana] has begun a full-blown codification of its conflicts law." [\[FN89\]](#) She speculates about the likelihood of this examination of conflicts law moving "more generally from scholarly journals to statutory formulations." [\[FN90\]](#)

The same may be said of Sarbanes and whether its tenets will find their way to the nonprofit health care sector. The best vehicle for such a journey, as suggested in this paper, is via JCAHO standards for governance and leadership developed and monitored through health information technology. Substantial fraud takes the form of incorrect reporting of diagnoses or procedures to maximize payments, fraudulent diagnosis, and billing for services not rendered. Information technology has achieved, and will further achieve, the capacity to detect previously difficult-to-detect and low-level accumulative fraud. [\[FN91\]](#) *478 Improved fraud detection will benefit all stakeholders--most notably, providers with enlightened leadership.

The bridge between the government and providers is the JCAHO. Its strength and effectiveness will ultimately depend upon the relationship between Medicare and JCAHO. [\[FN92\]](#) The federal government's reliance on the private accreditation structure of JCAHO, and its obvious self-interest membership and control, has been seen as suspect by those who fear that self-regulation is a poor vehicle for protecting consumers. [\[FN93\]](#) Yet, despite such structural weakness and its admitted vulnerability to provider protection, I concur with the conclusion that "[t]he deemed status program . . . should be abandoned only if and when a more effective program can be devised to policy and to encourage quality institutional health care . . . [recognizing] . . . there is little reason to believe that such a program will be forthcoming." [\[FN94\]](#) As a result, I urge policy makers to give serious consideration to my Sarbanes-JCAHO model of nonprofit enforcement.

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[FN1]. NSPE Board of Ethical Review Case Study, No. 85-2. The case study addresses the private club conflict in the following scenario:

A county hospital board owns a hospital facility and contracts with a private health care provider to manage, administer, and generally operate a hospital facility. Engineer A, a principal in a local engineering firm, serves on the board of directors of the private health care provider. Certain engineering and surveying work will need to be performed at the hospital facility. Engineer A seeks and receives a contract from the private health care provider to perform the engineering and surveying work at the hospital. The decision to select Engineer A's firm was made by the private health care provider's board of directors and Engineer A participated in the decision.

Id. The author proposes that governance standards should prohibit the Engineer and his/her firm from being considered as a contractor. In other words, when a person agrees to serve on the board of a public or community nonprofit hospital, he/she forfeits the opportunity to conduct business with the hospital. I find the argument that such a policy would preclude participation by some of a community's most capable leaders to fail in my experience, suggesting that the pool of persons capable and willing to serve on hospital boards generally is broad and deep.

[FN2]. See generally [Valley Hosp. Ass'n v. Mat-Su Coal. for Choice, 948 P.2d 963 \(Alaska 1997\)](#) (holding that a private, nonprofit community hospital was a "quasi-public" facility subject to compelling state interest).

[FN3]. [County Bd. of Equalization v. Intermountain Health Care, 709 P.2d 265, 271 \(Utah 1985\)](#) (commenting on "the increasing irrelevance of the distinction between nonprofit and for-profit hospitals for purposes of discovering the element of charity in their operations").

[FN4]. [Id. at 271-72.](#)

[FN5]. [Id. at 271.](#)

[FN6]. [Id. at 271-72.](#)

[FN7]. Joan H. Krause, [A Conceptual Model of Health Care Fraud Enforcement, 12 J.L. & Pol'y 55, 59 n.17 \(2003\).](#)

[FN8]. Clark C. Havighurst, Health Care Law and Policy 206 (1988). The parent's ability to operate this network and to subsidize the hospital from its earnings is ensured by applying as a "supporting organization" of the hospital for the status of a nonprivate foundation, or public charity, under [Internal Revenue Code section 509\(a\)](#). Id. See [I.R.C. § 509\(a\) \(1983\)](#).

[FN9]. Mark Pauly & Michael Redisch, The Not-for-Profit Hospital as a Physicians' Cooperative, 63 Am. Econ. Rev. 87, 87 (1973) (quoting William Baumol & Howard Bowen, On the Performing Arts, 55 Am. Econ. Rev. Proc. 495, 497 (1965)).

[FN10]. U.S. Hospitals: Mission Versus Market, 25 Health Affairs 10, 10 (2006).

[FN11]. John K. Iglehart, U.S. Hospitals: Examining Their Fraying Social Contract, 25 Health Affairs 8, 8 (2006). In 2003 there were 5,764 hospitals, which generated revenues of \$498.1 billion. Id. They "operated some 965,000 beds and cared for 36.6 million inpatients." Id.

[FN12]. Christopher P. Tompkins, Stuart H. Altman & Efrat Eilat, The Precarious Pricing System for Hospital Services, 25 Health Affairs 45 (2006) (discussing the development of the current pricing system for hospital services).

[FN13]. Id. (commenting on news stories that have "exposed" inexplicable charges for hospital products and services such as the \$5 aspirin).

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[FN14]. A notable example of "your doctor as your insurance company" is DakotaCare, a South Dakota for-profit healthcare insurer created and owned by physician members of the state medical association. Established some seventeen years ago to blunt the influence of private third-party payers, it has become a model of organized physician influence in the private insurance market.

[FN15]. Three such lawsuits were initiated in South Dakota in 2005 against the state's three healthcare systems: Sioux Valley, Avera, and Rapid City Regional. See *Burgher v. Rapid City Regional Hospital, Inc.*, Civ. No. 05-107 (2005); *Nygaaard v. Sioux Valley Health Hospitals & Health Systems*, Civ. No. 05-391 (2005); *Dosch v. Avera Health*, Civ. No. 05-302 (2005). All three lawsuits, filed as class actions, were dismissed during 2005 and 2006 in state trial courts on Rule (b)(5) motions to dismiss and as of this writing each is being appealed to the South Dakota Supreme Court. See *id.*

[FN16]. Gerard F. Anderson et al., *Health Spending in the United States and the Rest of the Industrialized World*, 24 *Health Affairs* 903, 904-05 (2005).

[FN17]. Centers for Medicare & Medicaid Services, *National Health Care Expenditure Projections: 2005-2015*, Table 1, <http://www.cms.hhs.gov/NationalHealthExpendData/downloads/proj2005.pdf> (last visited May 2, 2006).

[FN18]. Gerard F. Anderson et al., *Health Spending in the United States and the Rest of the Industrialized World*, 24 *Health Affairs* 903, 904-05 (2005).

[FN19]. *Id.* at 903.

[FN20]. Timothy Stoltzfus Jost, [Medicare and the Joint Commission on Accreditation of Healthcare Organizations: A Healthy Relationship?](#), 57 *Law & Contemp. Probs.* 15 (1994). Jost describes the makeup of the JCAHO:

The JCAHO is a private, nonprofit corporation that currently accredits more than 9000 health care institutions, including about 5,400 hospitals. Its 26-member board includes 21 commissioners appointed by the American Medical Association (seven commissioners), the American Hospital Association (seven), the American College of Physicians (three), the American College of Surgeons (three), and the American Dental Association (one). The remaining commissioners consist of one nurse and... six... members of the general public.

Id. at 15-16.

[FN21]. Panel of the Nonprofit Sector, *Strengthening Transparency Governance, Accountability of Charitable Organizations* 4-10 (2005).

[FN22]. See Dana Brakman Reiser, [ENRON.ORG: Why Sarbanes-Oxley Will Not Ensure Comprehensive Non-profit Accountability](#), 38 *U.C. Davis L. Rev.* 205 (2004).

[FN23]. *Id.* at 207-08. Professor Reiser explains the mixed feelings of attorney generals on Sarbanes:

Likewise, the Sarbanes-Oxley type legislation being proposed by activist [attorney generals] strives to improve the financial transparency and financial integrity of nonprofits. State [attorney generals] rightly worry about the misuse or waste of nonprofit assets and their prioritization of this aspect of enforcement may be appropriate. But enforcing nonprofits' financial accountability alone is insufficient.

Simply protecting nonprofit assets from theft and charitable contributions from misdirection is not enough to ensure comprehensive nonprofit accountability.

Id.

[FN24]. See *id.* at 214-15. "Maintaining organizational accountability is of both independent and instrumental importance. Legal compliance is independently significant because it serves the inherent values of order and predictab-

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ility, and allows for individual nonprofits and the nonprofit sector to maintain their claims to autonomy." *Id.* at 215.

[FN25]. Author Michael Myers served as CEO of Mayo-St. Mary's Hospital in Rochester, Minnesota, and CEO of Fairview Riverside Medical Center in Minneapolis, Minnesota, during a seventeen-year sabbatical from academia. These positions, inflation adjusted, now yield salaries in the \$300,000 to \$450,000 range.

[FN26]. This is not unnatural, as the "drive to acquire" and the "drive to defend" what has been acquired has been determined to be largely brain-based. See Paul R. Lawrence & Nitin Nohria, *Driven: How Human Nature Shapes Our Choices* (2002). Lawrence and co-author Nohria, Harvard Business School professors, theorize that human behavior is motivated by the internal struggle among our four brain-based drives: to acquire, to bond, to learn, and to defend. See *id.* The CEO position is part of the drive to acquire; once there, the drive to defend the position becomes paramount.

[FN27]. The author relies upon his experience as a CEO to inform health administration students on how top executives are able to create a board dependency that fosters support and loyalty to the CEO. One strategy is to engage consultants to design a system structure with five to six "physician-directed" subsidiaries, each having a medical director that is salaried by the system. The strategic placement of three or four such physicians on various boards within the system creates the type of dependency that strengthens personal loyalty to the CEO. Additionally, board members are selected from financial institutions, law firms, construction companies, and telecommunication companies that do business with the system.

[FN28]. Stephen M. Shortell & Arnold D. Kaluzny, *Health Care Management: Organization, Design and Behavior* 241-69 (1994) (discussing different organizational designs of health care organizations).

[FN29]. *Id.* This official system of accountabilities, control, and influence, however, does not fully represent what transpires between managers, physicians, and other groups of health care providers.

[FN30]. Deloitte, *In the Dark: What Boards and Executives Don't Know About the Health of Their Businesses* (2004) (presenting the results of a joint survey conducted by Deloitte LLP and the Economist Intelligence Unit).

[FN31]. *Id.* at 1.

[FN32]. *Id.*

[FN33]. Francis J. Serbaroli, *Sarbanes-Oxley and Corporate Governance of Non-Profits*, 230 N.Y. L.J. 3, Nov. 28, 2003.

[FN34]. *Id.*

[FN35]. *Id.*

[FN36]. Susan Carhart, *Provider Regulation: Health Lawyers See Lessons for Hospital Operations in Recent Lawsuits, Settlements*, 14 Health L. Rep. 979 (2005). Carhart advises nonprofit hospitals to "not be tempted by headlines such as the Wall Street Journal's June 29 'Acquittal Casts Cloud Over Sarbanes-Oxley Law' or the tagline 'SOX on the Rocks' to think they can afford to ease up on the good corporate governance compliance measures that law ushered in." *Id.*

[FN37]. *Id.*

[FN38]. Michael J. Myers, *South Dakota Hospital Price Disclosure Law: Spittin' into the Healthcare Wind?*, S.D. Bus. Rev., June 2005, at A1.

[FN39]. Consumers Union, Momentum Starting to Build in Favor of Hospital Infection Rate Disclosure (May 5, 2004), http://www.consumersunion.org/pub/core_health_care/001048.html (identifying the states that are pushing for such legislation, including Florida, Missouri, California, Pennsylvania, and Illinois) (last visited Mar. 20, 2006). In fact, "approximately 2 million people fall victim to hospital-acquired infections each year." Id.

[FN40]. Lawrence M. Brauer & Leonard J. Henzke, Jr., IRS EO CPE Text for Fiscal 2004: Automatic Excess Benefit Transactions Under [IRC 4958](#) (Dec. 30, 2003), http://www.pgdc.com/usa/print_item/?itemID=99255 (last visited Apr. 3, 2006).

[FN41]. Gilbert Gaul, Accreditors Blamed for Overlooking Problems, Wash. Post, July 25, 2005, at AO1.

The creators of Medicare faced a problem. They were about to hand out millions--eventually billions--of dollars each year in tax money for hospitals to care for the nation's elderly. But how to make sure those hospitals were qualified? Government bureaucrats had no experience overseeing the quality of health care, so in 1965 lawmakers turned instead to a private group--a little known organization that already was in the business of evaluating hospitals. The responsibility as Medicare's gatekeeper came as a shock to the Joint Commission on the Accreditation of Health Care Organizations, which never lobbied for it.... It was a complete surprise.

Id. (quoting Dennis O'Leary, President of JCAHO).

[FN42]. Id. Revenues are received mainly from fees JCAHO charges hospitals for conducting accreditation surveys. Id.

[FN43]. See id. While JCAHO has granted accreditation to 99 percent of hospitals surveyed, "in recent years it has missed glaring examples of poor care in which patients have been injured or killed...." Id. "Nelson J. Sabatini, Maryland's health commissioner during the troubles at Maryland General, said federal oversight of health care is 'a fraud. A lot of what they call regulation is really self-regulation[.]... They're being told to be partners. It doesn't work.'" Id.

[FN44]. [County Bd. of Equalization v. Intermountain Health Care, 709 P.2d 265 \(Utah 1985\)](#).

[FN45]. Id. at 271.

[FN46]. Id.

[FN47]. Pauly & Redisch, supra note 9, at 87. "It is typically assumed that 'all objectives of nonprofit organizations can be described in terms of some type(s) of output (broadly defined) or capital stock.' William Baumol and Howard Bowen describe these goals as 'bottomless receptacles [sic] into which limitless funds can be poured.'" Id. (quoting Baumol & Bowen, supra note 9, at 497).

[FN48]. John Sattenspiel, Broken Health System, Broken Heart, Statesman J., Jan. 29, 2006, at 15C, <http://159.54.226.83/apps/pbcs.dll/article?AID=20060129/OPINION/601290314/1049>.

[FN49]. Trudy Lieberman, Bruised and Broken: U.S. Health System: Older Americans Increasingly Face a System Coming Apart at the Seams, AARP Bulletin, Mar. 2003, available at <http://www.aarp.org/bulletin/yourhealth/a2003-07-02-bruised.html>. "[S]omething is wrong with the U.S. health-care system." Id.

[FN50]. Sattenspiel, supra note 48.

[FN51]. PriceWaterhouseCoopers, First in a Series, Sarbanes-Oxley Relevance and Implications of Certain Provisions for Non-Public Healthcare Organizations (2004). "As the emphasis being placed on better corporate governance seeps over to not-for-profit organizations, Sarbanes-Oxley may be the template for future regulations gov-

erning them." Id. at 1.

[FN52]. Id.

[FN53]. Id.

[FN54]. Id.

[FN55]. Joint Comm'n on Accreditation of Healthcare Orgs., JCAHO Accreditation Requirements--Policies and Procedures for JCAHO Accredited Organizations, <http://www.popmanual.com/jcaho> (last visited March 20, 2006) [hereinafter JCAHO].

[FN56]. Id.

[FN57]. Id.

[FN58]. Id.

[FN59]. The Joint Commission 1995 Accreditation Manual for Hospitals, Standards 67, 69 (JCAHO Vol. 1 1994).

[FN60]. Id.

[FN61]. Id.

[FN62]. Id.

[FN63]. Id.

[FN64]. As the chief operations officer and legal counsel for a 530-bed hospital, the author canceled an indirect purchase of fleet automobiles by a board member who had a relationship with an area automobile dealership that subsequently lost out to a competing bid. It was the first of a number of such experiences encountered with board members, often in collaboration of physicians.

[FN65]. JCAHO, *supra* note 55, at 69.

[FN66]. Id.

[FN67]. An entrepreneurial physician delivered that message to the author during the establishment of a physician-owned specialty hospital: "Conflicts of interest are exactly what we are looking for," he counseled as we attracted the initial ten physician investors.

[FN68]. BoardSource Knowledge Center, Q & As, How do we safeguard against conflict of interest?, <http://www.boardsource.org/Knowledge.asp?ID=3.389> (last visited Apr. 18, 2006).

[FN69]. Id.

[FN70]. Id.

[FN71]. Scott Green, *Manager's Guide to the Sarbanes-Oxley Act: Improving Internal Controls to Prevent Fraud* ix (2004).

[FN72]. Id. at 1.

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[FN73]. See Joan H. Krause, [Healthcare Fraud and Quality of Care: A Patient-Centered Approach](#), 37 *J. Health L.* 161 (2004).

[FN74]. *Id.* at 183-84.

[FN75]. *Id.* at 184.

[FN76]. Green, *supra* note 71, at 1.

[FN77]. *Id.*

[FN78]. *Id.*

[FN79]. *Id.* at 8.

[FN80]. *Id.* at 11.

[FN81]. *Id.* at 12.

[FN82]. John K. Iglehart, U.S. Hospitals: Examining Their Fraying Social Contract, 25 *Health Affairs* 8, 8 (2006).

[FN83]. Stuart Guterman, Specialty Hospitals: A Problem or a Symptom?, 25 *Health Affairs* 95 (2006).

[FN84]. Leslie Greenwald et al., Specialty Versus Community Hospitals: Referrals, Quality, and Community Benefits, 25 *Health Affairs* 106 (2006).

[FN85]. Jeffrey Stensland & Ariel Winter, Do Physician-Owned Cardiac Hospitals Increase Utilization?, 25 *Health Affairs* 119 (2006).

[FN86]. Joel S. Demski, Corporate Conflicts of Interest, 17 *J. Econ. Persp.* 51 (2003).

[FN87]. *Id.*

[FN88]. The author is a former chief operations officer of Mercy Medical Center, Sioux City, Iowa; former chief executive officer of Mayo-St. Mary's Hospital, Rochester, Minnesota, and Fairview Riverside Medical Center, Minneapolis, Minnesota; and spent seventeen years in the hospital field prior to returning to the University of South Dakota to teach at the Schools of Law and Business.

[FN89]. Carol S. Bruch, Codification of Conflicts Law: The Louisiana Draft, 35 *Am. J. Comp. L.* 255, 255 (1987).

[FN90]. *Id.* at 256.

[FN91]. IT Can Fight Healthcare Fraud, *Health Mgmt. Tech.*, Dec. 2005, at 8. Healthcare fraud "costs the government an estimated \$51 billion to \$170 billion a year. Automated coding software and an NHIN could offer 'substantial savings,' according to the reports commissioned by HHS' Office of the National Coordinator for Health Information Technology...." *Id.* The report estimates that healthcare information technology could save as much as \$15 billion. *Id.* However, it also acknowledges that "fraud-related costs exceed benefits in the early stages of an NHIN, and benefits only exceed costs when an NHIN is in intermediate to advanced state." *Id.* JCAHO accreditation standards could reinforce the guiding principles of an NHIN, including (1) "[a]n NHIN to 'proactively prevent, detect and reduce healthcare fraud, rather than be neutral to it"; (2) a standardized minimum for the definition of a legal health record, and (3) established healthcare management that is accountable to all healthcare stakeholders, including consumers. *Id.*

[\[FN92\]](#). See Jost, *supra* note 20, at 18-22.

[\[FN93\]](#). *Id.* at 45. Jost contends, "[t]he Joint Commission could and should be more accountable to the public and more rigorous in the application of its accreditation standards... [and]... the federal government should be more rigorous in its validation process to assure the quality of Joint Commission decisions." *Id.*

[\[FN94\]](#). *Id.*

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