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The Collision of Healthcare and Corporate Law in a Hospital Closure Case

Scott M. Himes

AMERICAN HEALTH LAWYERS ASSOCIATION

SAINT LOUIS UNIVERSITY SCHOOL OF LAW

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ABSTRACT: This Article analyzes potential conflicts that arise from both the judicial and administrative approval processes that govern the closure of charitable hospitals through a sale of all or substantially all of their assets. Examining the recent closure attempt by the Manhattan Eye, Ear & Throat Hospital as an example, the Article highlights the various public health and corporate law issues that are raised when a not-for-profit hospital seeks closure. The Article thoroughly discusses both the statutorily and judicially required approval schemes applicable to the closure of charitable hospitals. The Article also suggests ways in which these conflicts might be avoided or remedied, as well as gives advice regarding hospital board decisionmaking.

An important recent case involving the attempt to close a New York City hospital, *In re Manhattan Eye, Ear & Throat Hospital v. Spitzer,*[1] illustrates a serious clash of corporate law and public health issues. Two related bodies of law—a state's Not-for-Profit Corporation Law and regulations of the state's health department—are involved.

The provisions relating to hospital closure in both areas of law, one based in legislative judgment, the other in administrative determination, are fairly undeveloped, having received little attention from the courts in the past. The attempt to close the Manhattan Eye, Ear & Throat Hospital ("MEETH") highlights the

* The author is a partner in the New York City law firm Stillman & Friedman, P.C. He and his firm were counsel to the hospital medical staff in the litigation and other matters discussed in this Article. The facts and circumstances addressed in this Article are based on court proceedings, other public records, and the author's knowledge gained from his representation; views expressed are based on the author's first-hand involvement in representing the medical staff in its efforts to prevent the hospital's closure.

conflicts and the potential serious harm to both the valuable charitable asset of a hospital and important public health concerns resulting from the separate corporate law and public health standards that govern a hospital closure under the dual approval requirements. The attempt to close MEETH and the resulting litigation also speak volumes about another important issue: the process by which the board of directors of a charitable institution decides on closing the institution, and how that process can go wrong.

MEETH is a specialty care hospital located on the Upper East Side of Manhattan, which exists as a charitable not-for-profit corporation.[2] In early 1999, MEETH's Board of Directors decided to close MEETH as a hospital and sell its real estate, expecting to receive about $40 million.[3] The Board planned to use the sale proceeds to develop an undetermined number of small clinic-like facilities, known as "diagnostic and treatment centers," in outlying areas around New York City.[4] Closing MEETH required approval of the Commissioner of New York State's Department of Health ("DOH") pursuant to DOH regulations. In addition, since the closure would result from MEETH selling substantially all of its assets and MEETH is a charitable corporation, the sale needed court approval under New York's Not-for-Profit Corporation Law ("N-PCL").[5] Two approval regimes thus governed MEETH's proposed closure.

Against various parties' opposition, MEETH eventually sought both DOH and judicial approval for its proposed closure and asset sale. Although MEETH vigorously pressed for administrative approval, the DOH never decided MEETH's request to close. On the judicial path, however, after a lengthy trial on MEETH's N-PCL petition, the state trial court disapproved MEETH's proposed asset sale, thereby preventing the closure.[6]

But before the court ended the Board of Directors' attempt to close it, MEETH—caught in a kind of regulatory purgatory—teetered on the brink of collapse.

This Article discusses, from the benefit of the MEETH experience, how conflicts can arise from the dual approval process that governs when a charitable hospital wants to close through a substantial asset sale. The separate approvals are grounded in very important, albeit different, public policy considerations. Yet the lack of consistency and coordination in the approval regimes can threaten the very existence of a hospital—which typically

"belongs" to the public as a charitable asset—and can pose serious public health risks that should always be evaluated when a hospital wants to close. As a result, there is great need to harmonize these related, yet different, decisionmaking and approval processes to protect charitable assets and promote health concerns in future hospital closings both in New York and elsewhere.

After first discussing the circumstances of MEETH's attempt to close, this Article describes the separate administrative and judicial approval schemes that apply to a hospital closure. Against the backdrop of the troubling conflicts and inconsistencies manifested in the MEETH situation, the Article then proposes some ways to address these problems. This discussion also illuminates some important considerations in achieving sound decisionmaking when a nonprofit board considers a transaction that will close its institution.

I. The Circumstances of MEETH's Attempted Closure

A. MEETH Before the Closure Events

MEETH was created by special state legislation in 1869.[7] Throughout its 130-year existence, MEETH's medical mission, as stated in its corporate charter, has been to operate a hospital devoted exclusively to the specialty fields of ophthalmology, otolaryngology (ear, nose and throat, or "ENT," care) and, more recently, plastic and reconstructive surgery.[8] MEETH mainly provides secondary and tertiary care in its specialties—meaning more sophisticated care involving complicated and difficult health problems, requiring high levels of medical expertise.

While MEETH operates an inpatient hospital for surgical cases and acute illness, outpatient clinics, ambulatory surgery, and an emergency room provide much of MEETH's specialized care. Of particular significance to the issue of MEETH's closure, MEETH for many years afforded care to the community through its in-house Eye and ENT Clinics (as well as through those clinics' subspecialty facilities treating patients needing even more highly specialized care). Over the past several years, MEETH's clinics have handled about 80,000-90,000 patient visits per year, with the majority of patients being indigent and elderly.[9] Beyond providing patient care in its specialty fields, MEETH has long undertaken basic and clinical research and provided postgraduate medical education in its fields. These activities are also stated purposes under its charter.[10]

In its opinion disapproving MEETH's proposed asset sale, the court found that MEETH "has outstandingly realized" its medical care purposes.[11] The court noted that MEETH's physicians "have achieved world acclaim for their advancements in medical care and for their provision of acute care in these specialty areas," that MEETH has developed premier residency and fellowship training programs in ophthalmology, otolaryngology and plastic surgery, and that MEETH, in short, "has consistently been ranked among the top specialty hospitals in the United States."[12]

Nonetheless, like most of the healthcare industry, MEETH in recent years has encountered serious financial problems as a result of changes in healthcare economics.[13] Based upon its own detailed analysis, the medical staff by 1998 had concluded that MEETH's Board and administration were not addressing these changes adequately and were mismanaging MEETH. The medical staff thus submitted a lengthy memorandum to MEETH's Board, which described MEETH's operational and financial problems and recommended specific steps to correct them.[14] Shortly thereafter, in late 1998, members of the medical staff addressed these problems at a meeting with Board members.[15] But instead of trying to solve the problems, the Board soon set upon a course to sell MEETH's real estate and close MEETH as a functioning hospital.

B. The Board's Decision to Sell MEETH's Real Property and Close the Hospital

In January 1999, MEETH received a bid from Memorial Sloan-Kettering Cancer Center ("MSKCC"), another New York City hospital, to buy MEETH's real estate.[16] MEETH then hired a financial advisor to consider the MSKCC offer, and also to assess MEETH's "strategic options."[17]

The advisor concluded that MEETH's business as a specialty care hospital had no ongoing economic value.[18] The advisor also opined that MEETH's real estate—located on Manhattan's Upper East Side—had considerable value and should be sold as part of "refocusing" MEETH's mission into new "diagnostic & treatment centers."[19] When the *MEETH* court subsequently evaluated these events based on the trial evidence, the court held: "[i]t was this mindset, that the real estate was the only asset of MEETH with value, which determined the future course of events. As [MEETH's advisor] put it, the Board wanted to 'monetize the assets,' rather than seek to preserve MEETH as its main priority."[20]

Thus, in late February 1999, the Board voted to sell MEETH's real estate for a price as near as possible to $45 million.[21] The Board also authorized filing the necessary applications for regulatory and judicial approvals.[22] The medical staff and other affected parties were not informed about these major decisions at the time. Significantly, the *MEETH* court found that prior to these decisions, "there was interest from other medical institutions in seeking to preserve MEETH as a world-class teaching and research hospital, which [was] ignored by the Board" in accepting the advisor's recommendation to sell the real estate.[23]

On April 25, 1999, *The New York Times* reported that MEETH's directors "are getting out of the hospital business" and "have put their hospital up for sale."[24] The article stated that the Board expected that more than $40 million would be received for selling MEETH's real estate to a developer and that the Board planned to use the sale proceeds "to open outpatient clinics in several poor neighborhoods."[25] The *Times* article was the first widespread notice that MEETH's Board had decided to sell MEETH's real estate and close the hospital.

A few days after that article, at a meeting on April 29, the Board made several important decisions to advance its plans. First, it voted again to sell the hospital, at a price in excess of $40 million.[26] It authorized MEETH's administration to prepare for closing the hospital and to give notice of termination to MEETH's residents (the recent medical school graduates receiving specialized training in MEETH's fields, who were integral to MEETH's day-to-day functions).[27] It again authorized the administration to seek regulatory and judicial approvals for its decisions, and it also authorized (but did not actually submit or file) an amendment to MEETH's corporate charter to encompass running the new clinics, which were to be the main use under its plan for the sale proceeds.[28] Significantly, although authorized by the Board, MEETH did not make any filings for approval to close at this time.

After hearing the trial evidence, the *MEETH* court found that in late April the Board had not performed or obtained any study or management plan to support establishing new clinics, even though closing MEETH as a hospital to create these clinics was a "momentous decision."[29] Indeed, the Board did not engage healthcare consultants to evaluate this new clinics plan until much later, at a meeting on July 26. The court found that the Board's doing so at that late date simply resulted in the consultants endorsing the Board's already determined plan.[30]

By early May, MEETH had received several proposals to purchase its real estate. On May 5, the Board voted to accept a joint bid of $41 million from MSKCC and a real estate developer.[31] That same day, MEETH executed a "letter of intent" to sell its real estate to MSKCC and the real estate group.[32] MEETH subsequently described this document (including in court proceedings) as a "binding" commitment that included a "no-shop" clause, therefore invoking it as grounds not to negotiate with other bidders.[33] After considering the proof at trial, the *MEETH* court held that "the letter of intent was not binding, . . . that it did not contain a no-shop clause . . . [and that] there was nothing in the non-binding letter which would have prohibited MEETH from actually seeking to preserve its mission [by negotiating with other bidders]."[34]

The *MEETH* court also noted that on May 5 the Board discussed the issue of closing the hospital only *after* having approved the sale, and that, according to the meeting minutes, "*no* actual decision had been made to close the Hospital."[35] Criticizing the approach to pursuing closure, the court noted that on April 29 the Board had terminated MEETH's residency programs and had authorized its administration to prepare for possible closure, but that "even as of May 5th . . . the Board did not seem to believe that it was actually closing the Hospital. One has to wonder exactly what the Board thought it was doing."[36]

Also, shortly after the *Times* article, New York's Attorney General actively entered the picture.[37] Typically, before a petition under the N-PCL is filed in court, the Attorney General informally reviews the proposed transaction.[38] The Attorney General considers both the proposed sale itself and the proposed disposition of any sale proceeds. Starting early on, the Attorney General thus sought information about MEETH's proposed transaction and met with MEETH's representatives to try to learn more about it.[39]

In accord with DOH regulations, MEETH also needed regulatory approval to close. Although authorized weeks earlier, MEETH did not file its plan for closing the hospital with the DOH until June 14.[40] Noting that since the Board previously had decided to terminate MEETH's residents effective June 30, the closure plan proposed discontinuing the patient care services affected by resident staffing, including the outpatient clinics, the emergency services covered by residents and the inpatient activities covered by residents on call, as of June 30—barely two weeks after the DOH filing was finally made.

On a Sunday evening in late June, MEETH, having accepted the bid in early May, entered into a contract with MSKCC and the real estate developer to sell its real property to them.[41] Under the terms of the proposed transaction, MSKCC intended to develop MEETH's newer facilities into a breast cancer center, and the real estate developer expected to develop the remaining older property into apartments or other residential units.[42] The contract required MEETH to file its petition for judicial approval of the sale within sixty days or, in other words, by late August.[43] Nonetheless, MEETH failed to do so. The *MEETH* court determined that there had been no explanation for failing to file in accordance with the contract, but it stated that "there is no doubt that MEETH was putting off instituting the judicial petition while awaiting the hoped-for DOH approvals for the closure and [diagnostic and treatment center] plans."[44] As it turned out, MEETH would not file its petition for judicial approval until late September.[45]

C. The Subsequent Events Surrounding the Board's Efforts to Sell and Close

Despite the sales contract with MSKCC, several institutions and others remained extremely interested in transactions to acquire MEETH that would enable MEETH to continue its basic medical care mission. As a result, in June and July, Lenox Hill Hospital and Continuum Health Partners, Inc., (which includes Beth Israel Medical Center, St. Luke's-Roosevelt Hospital and other prominent New York City healthcare facilities) made new proposals to acquire MEETH.[46] Although these new proposals differed significantly from one another, both shared one salient aspect: to preserve MEETH substantially as it existed and thus continue MEETH's core charitable medical purposes set forth in its charter.[47]

Also during the summer of 1999, the Attorney General, through his Charities Bureau, became increasingly involved in monitoring and reacting to MEETH's conduct and plans.[48] Over time, the Attorney General became increasingly concerned about the propriety of the Board's actions. Indeed, the medical staff and others had complained to the Attorney General that MEETH was not providing information to various interested buyers and, generally, was not acting in MEETH's best interests.[49]

The Attorney General soon concluded that MEETH's Board was not properly considering the new proposals to acquire MEETH that would preserve MEETH's charitable mission. For example, in

a June letter, the Attorney General advised MEETH that "[w]e are not aware of . . . one single shred of evidence that MEETH is actively exploring in good faith all or even any of these expressions of interest [which would preserve MEETH]"—a statement that the MEETH court found "proved to be accurate."[50] The Attorney General subsequently continued to advise MEETH that it objected to the Board's decisionmaking process and expressed concern that the Board was not furthering MEETH's charitable mission.[51]

MEETH's plan to sell and close, and various parties' efforts opposing it, also involved another front over the summer months—the DOH. Shortly after MEETH filed its closure plan with the DOH in mid-June, the medical staff filed objections to the plan. Also soon after the filing, the DOH informed MEETH that until the DOH approved the plan, MEETH was not permitted to discontinue operation. The DOH instructed MEETH that it must assure adequate staff coverage, equipment, and supplies so as to maintain its operation as a licensed healthcare facility, including sufficient emergency room and clinic coverage.

Despite this admonition, and even while the DOH was considering the closure plan, MEETH's Board and administration took numerous steps over the summer to "wind down" MEETH's operations. For example, in addition to having previously decided to terminate the residents,[52] the medical staff asserted that from July into September the Board and administration: (a) terminated other employees, including some with important patient care responsibilities; (b) failed to provide adequate staffing for patient care, particularly for the clinics and at times even the emergency room; (c) curtailed the availability of care in the clinics and cancelled patients' appointments; (d) reduced the availability and hours for operating rooms and made it difficult for physicians to schedule surgery; (e) failed to maintain some important surgical equipment; (f) evicted from the hospital certain physicians who had long maintained offices there; (g) instructed security personnel to search people's bags as they entered and left the hospital; (h) reportedly failed to order necessary drugs, neglected hazardous waste, and came close to causing the hospital's computer operations to be shutdown for failing to pay the hospital's service contract vendor; and (i) eventually, sent a letter to patients stating that the Board had decided to close MEETH and listing supposed alternate healthcare providers. Indeed, as a dynamic, living institution, these actions—like the announced plan to close itself—threatened a self-fulfilling prophecy of collapse, causing many of MEETH'sphysicians, residents, nurses, other professionals, and

staff to seek other professional affiliations and new jobs. And all of this occurred without the DOH approving MEETH's closure plan and before MEETH had even filed its judicial petition for approval of its asset sale.

Throughout the summer, MEETH's medical staff and employees thought that MEETH was very near to closing *de facto*—that is, even though the DOH had not approved closure, MEETH's operations had been so severely curtailed and its basic functioning so severely harmed that MEETH would be forced to close its doors.[53] As an obvious consequence of the Board and administration so substantially limiting the hospital's activities, MEETH's financial condition rapidly deteriorated. Another serious consequence was the potential effect on the existing bids for MEETH. The other institutions wanted to acquire MEETH as a going concern, so that MEETH's failure probably would have killed those bids.

While MEETH seemed on the brink of a shutdown over the summer, the medical staff and others constantly communicated with the DOH, urging that it prevent MEETH from pursuing a course of conduct that would lead to MEETH's collapse. Significantly, while events were leading to MEETH's collapse during this time period, MEETH still refrained from filing its petition for judicial approval of its real estate sale.

Finally, on September 21, 1999, no doubt due to continuing pressure from the Attorney General, MEETH filed that necessary N-PCL petition.[54] With the matter of MEETH's real estate sale and closure then within a court's jurisdiction, the Attorney General promptly moved for a preliminary injunction to enjoin MEETH from taking any action to wind down operations, reduce its services, or implement a closure plan before obtaining DOH and court approval. The Attorney General also moved for leave to file a third-party complaint against MEETH's Board members and its executive director, seeking money damages and an accounting based on claims for waste of MEETH's charitable assets from an alleged breach of fiduciary duties.[55]

In connection with the Attorney General's motion, the court entered a temporary restraining order on September 30 that prohibited MEETH from taking any action to wind down its operations or to stop operating as a fully functioning hospital, pending the hearing on the motion. That TRO helped stabilize MEETH's operations somewhat, and it lessened the immediate threat of a *de facto* closure.

D. The Court's Decision and Its Aftermath

In October, having considered MEETH's N-PCL petition very promptly, the court merged the preliminary injunction application with a trial on the merits of the N-PCL petition.[56] Other than one half-day deposition of MEETH's executive director, there was no discovery preceding the N-PCL trial. Various interested parties, including MEETH's medical staff, the union representing its employees and the union pension fund, the institutions that had submitted competing bids, and MSKCC and the developer group, joined in the litigation and participated in the trial. The trial lasted thirteen days, and the court issued its decision on December 3.[57]

Based upon detailed fact-findings and a thorough legal analysis, the court denied MEETH's petition for approval of the real estate sale.[58] The court held that the proposed sale failed to meet the N-PCL Section 511 two-part test of proper consideration and furtherance of MEETH's charitable purposes.[59] The court found that the proposed use of the charitable assets—establishing new clinic-like facilities with the sale proceeds—involved "a new and fundamentally different corporate purpose" than prescribed under MEETH's charter.[60] The court emphasized that in the first instance, the board of a not-for-profit must seek to preserve the corporation's original mission, but MEETH's Board did not make a "reasoned and studied determination" that MEETH could not survive as a hospital.[61] Instead, as the court held, MSKCC's original offer caused the Board to recognize the underlying value of MEETH's real estate, and the realization that the Board could "monetize" this asset drove the decision to change MEETH's purposes and the other subsequent events.[62] The court found it very significant that the Board might not have received disinterested advice because its strategic advisor had a financial interest in its recommendation, which posed a conflict of interest.[63] The court also emphasized that the Board had failed to consider properly the various alternative proposals that would have preserved MEETH's mission.[64]

In short, the court held that the proposed sale did not meet MEETH's corporate purposes because MEETH first decided to sell and "then evolved its new or 'reprioritized mission,'" and only then sought DOH approval to close and "judicial imprimatur of this plan."[65] Further, under the N-PCL test, the court found that the Board had improperly disregarded important components of MEETH's value in deciding to "monetize" by selling its real estate.[66] This was an additional ground for disapproving the proposed real estate sale.[67]

After the court issued its decision, the Board agreed to undertake a new bidding process for offers to acquire MEETH. At the Attorney General's urging, the Board formed a special committee that considered several formal bids received in late December, and shortly afterwards recommended one of the bids to the Board. In mid-January 2000, the Board voted to accept the new proposal from Lenox Hill Hospital.

Soon thereafter, MEETH and Lenox Hill entered into a sponsorship transaction under which Lenox Hill acquired control of MEETH as MEETH's sole corporate "member." This kind of sponsorship arrangement enables one not-for-profit medical institution (generally, the financially stronger entity) to acquire another (weaker) not-for-profit facility. Under the agreement, Lenox Hill committed to maintain MEETH as a specialty care hospital and to continue MEETH's charitable mission. Throughout the post-decision events, the Attorney General actively and carefully oversaw and monitored the process. Today MEETH has a new Board of Directors (which, unlike most of the previous boards, includes physicians from MEETH's medical staff) and new management furnished by Lenox Hill. In light of this transaction, MEETH should continue as a specialty care hospital substantially as it has functioned in the past, now under Lenox Hill's auspices and management.

II. The Regulatory Process Governing Hospital Closure

A. The DOH Regulations

Regulatory approval for closing a hospital is required because healthcare is a heavily regulated industry with broad and important public policy concerns. Just as establishing a hospital requires administrative approval for a license to operate, so too must closing the hospital be administratively approved. Scrutiny to assure that closure meets the public interest should be critical. While very little reported case law deals with regulatory approval for closing a hospital or other medical facility, one important New York Court of Appeals case, *Birnbaum v. State of New York*,[68] considered such approval against public health considerations.

In *Birnbaum*, the State obtained receivership over a nursing home (a medical facility governed by DOH regulations similarly applied to hospitals) to prevent the nursing home from being closed precipitously, in contravention of a DOH regulation requiring approval to close.[69] The nursing home's owners asserted that the state-imposed receivership, which effectively

required the facility to remain open against their will, constituted a "taking" of property entitling them to be compensated under the federal and state constitutions.[70]

The court rejected that argument, holding that even though the facility continued to run at a deficit, applying the DOH closure-approval regulation to require the nursing home to remain open under receivership did not constitute an immediate taking of the owners' property.[71] The court emphasized that a nursing home, like a hospital, exists based on an administratively-determined public need for its services and through a regulatory scheme designed to match supply with demand. Thus, closing the facility can create a medical care shortage that poses public health risks:

> [The owners] possessed the exclusive right to operate a nursing home solely because the public interest, as assessed by the Legislature and the Department of Health, required exclusivity. This grant by the State, while benefiting the [owners], also put them in the position to create an immediate scarcity of medical care if services were terminated abruptly. When the State confers an exclusive franchise upon an individual incidental to providing a public good, it need not subject itself to the uncontrolled discretion of the individual to instantaneously create a public emergency. Instead, we conclude that the State may enforce the obligation, embodied in a regulation, that there shall not be immediate termination of nursing home services, because that use of the property threatens an imminent injury to the public.[72]

Although receiving regulatory approval before a medical facility can close is crucial to avoid harm to the public health, New York's DOH has promulgated only very limited standards for a closing. The applicable provisions are under a regulation entitled "Changes in existing medical facilities."[73] The basic closure-approval provision states simply: "No medical facility shall discontinue operation or surrender its operating certificate unless 90 days' notice of its intention to do so is given to the commissioner [of the DOH] and his written approval obtained."[74] As the court noted in *Birnbaum*, this provision imposes a time constraint to prevent an immediate closing of a healthcare facility, without first obtaining the DOH's approval.

Only two other DOH provisions specify what a hospital actually must do for closure. First, upon obtaining approval for a "voluntary surrender" of a hospital's operating license, the hospital must so notify each patient (or a patient's relatives or physician) and "shall discharge or transfer all patients or residents to other appropriate facilities prior to discontinuing operation."[75] Second, before a medical facility can discontinue operation or surrender its operating certificate, it must also obtain the commissioner's written approval "of a plan for the maintenance, storage and safekeeping of its patients' medical records."[76] The plan must "provide adequate safeguards for these records, make them accessible to the patients and their physicians, and may provide for their ultimate disposition."[77]

These few provisions are the sum total of New York's DOH regulations that govern a hospital closure. In a nutshell, a hospital seeking to close needs to: (a) obtain the Commissioner's approval ninety days before closing; (b) tell patients of the intention to close and, as an obvious necessity, discharge or transfer all patients before closing; and (c) offer an acceptable plan for preserving and accessing patients' medical records.[78] Other states, similarly, provide few criteria in either their legislation or regulations for closing a medical facility.[79]

In short, while closing a hospital raises many serious issues, the formal regulations do not provide meaningful guidance for the closure; consequently, they do not provide meaningful protection for the public from harm that closure might cause. While "approval" of the DOH Commissioner is required, the regulations do not specify any criteria, standards, or factors to govern that approval determination. In the MEETH medical staff's dialogue with the DOH during the closure events, the agency's personnel acknowledged the sparseness of the written regulations. Indeed, although regulatory agencies generally are given wide discretion and flexibility in setting licensing standards within a statutory framework, it could be argued that the DOH closure regulations are so vague and uncertain as to be invalid.[80]

Undoubtedly because of this lack of specificity, the procedures a New York hospital follows for closure, and the DOH's resulting consideration, appear *ad hoc*. It is customary for a hospital seeking the Commissioner's approval to close to submit a "plan of closure." Again, however, there are no formal guidelines for the showing to be made in a closure plan. As a result, in the MEETH situation, an evolving *ad hoc* approach was employed to address the issues that repeatedly arose concerning the closure.

A critical issue for the DOH in any hospital closure situation should be the assurance of continuity of patient care. As the court of appeals emphasized in *Birnbaum*, a medical facility operates as a state-created "franchise" that exists in a carefully weighed balance of patient needs and economic considerations. The patient-care need exists for the facility's services, but an excess of services creates unnecessary healthcare costs. In this delicate regulatory milieu of care versus costs, a closure poses important patient care issues. How will the hospital's patients receive care in the future? Will they receive the same quality of care? Can the existing medical facilities in the area absorb them as new patients? How will patients know where they can get care? Is there a risk that some patients simply will not receive care if the facility is closed? These are vital public health concerns, and should be addressed in any hospital closure situation. The MEETH situation illustrated these concerns, and how they were nearly shortchanged in a precipitous and unnecessary closure.

B. The MEETH Experience with the DOH

As noted, MEETH's administration submitted a closure plan to the DOH in mid-June 1999.[81] The plan formally notified the DOH that MEETH intended to close, stating that MEETH would institute the closure plan once the Commissioner had approved it.

In varying degrees of detail, MEETH's plan addressed the following issues and subjects: (a) notifying patients, physicians, employees, and others of the closure; (b) discharging patients to other facilities; (c) maintaining, storing, and safekeeping patients' medical records; (d) maintaining continuing contacts with the DOH; (e) disposing of drugs and refuse; (f) setting up a closure "headquarters"; (g) providing plans for security and engineering/maintenance; (h) establishing staffing and personnel policies; and most importantly, (i) closing patient care services. Generally, however, the plan set forth proposed procedures for winding down MEETH's operations based upon the already-made determination to close and the assumption that approval would be quickly forthcoming.

MEETH's medical staff commented on the closure plan to the DOH. The medical staff addressed various particulars of the closure mechanics, such as monitoring and handling patient care matters as the hospital was shutting down, the nature of the hospital's proposed "closure team," and the notification process to patients.

Much more importantly, however, the medical staff addressed fundamental patient care issues that would arise from closure itself—how the medical community would absorb the large volume of MEETH's patients who would need care in the future, and how MEETH's patients would be able to receive the appropriate quality of care that they needed. Indeed, in commenting on the closure plan, the medical staff presented data to show that the existing medical facilities in the community could not absorb the large volume of MEETH's patients, particularly given the specialized nature of care MEETH afforded. In essence, the medical staff believed that all of MEETH's patients would not be able to receive appropriate care should MEETH be closed and, thus, that closure itself posed a serious public health risk.[82]

As the DOH considered MEETH's closure further, it requested additional information from MEETH's administration about the various issues the medical staff had raised. Significantly, the DOH required MEETH to provide information that would address continuity of care issues, such as where MEETH's patients would be able to receive continuing treatment and the basis for believing that MEETH's patients could be assimilated into the medical community's other facilities. In support of the position that MEETH should not be closed, the medical staff also continued to address these issues, asserting to the DOH that MEETH was a unique medical facility whose role in the medical community could not be replicated by other facilities. It also continued to insist that MEETH's patients simply would not obtain adequate comparable care elsewhere if MEETH were closed. In short, the medical staff asserted to the DOH that MEETH's closing would harm the delivery of needed medical care to the community and threaten the public health, with profound and far-reaching ramifications.

The DOH never approved MEETH's closure. Indeed, although the DOH regulation prohibits a hospital from closing sooner than ninety days after giving notice that it intends to do so, that language does not appear to require the DOH to act within any specified time—and in MEETH's case, DOH took the position that it did not have to act within the ninety-day period.

Once MEETH finally filed the N-PCL petition for judicial approval of the proposed real estate sale in late September 1999, the DOH held its further consideration of closure in abeyance, pending the N-PCL trial. Closure from the regulatory standpoint became moot—indeed, impermissible—when the court subsequently disapproved MEETH's proposed real estate sale.

The circumstances of MEETH's seeking regulatory approval to close underscore two important issues. First, there are very few criteria that apply to closure under the DOH regulations, and no explicit requirement that patient care needs be assessed in determining whether a hospital may close. In the MEETH situation, patient care became a central issue largely because the medical staff made it so by showing that the healthcare needs of MEETH's patients and the community in general would be harmed if MEETH were closed. However, in the absence of an influential group pressing the issue in the regulatory process, there is no certainty that this vital public health consideration will be appropriately considered. Simply put, given the lack of specificity in the DOH regulations, a hospital might be permitted to close without due and informed consideration of the closure's adverse effects.

Second, MEETH sought DOH regulatory approval to close well *before* it sought the required judicial approval for the sale of its real estate that would necessitate closure. No formal mechanism required, or even facilitated, that these two approval processes, although related in important ways, be coordinated. As a result, there was the real possibility that the DOH would have permitted MEETH to close, even though the court had not yet determined—or even had the opportunity to determine—whether the sale of assets was permissible under the N-PCL.

III. The Statutory Framework and Considerations Governing a Not-for-Profit Corporation's Sale of Assets

A. The Not-for-Profit Corporation Law Provisions (and Their Common-Law Roots)

MEETH is a charitable not-for-profit corporation, and thus is governed by the N-PCL's special statutory framework.[83] As noted, New York's N-PCL requires that a charitable corporation which wants to sell all or substantially all of its assets must obtain judicial approval of the proposed sale.[84]

The N-PCL sets forth several key elements for such a sale. First, a two-part test must be met. The consideration and terms of the transaction must be "fair and reasonable to the corporation," and the "purposes of the corporation" must be "promoted" by the sale.[85] Second, this test must be met "to the satisfaction of the court."[86] Third, the Attorney General must be given notice of the petition for court approval, and other interested parties can also

be afforded notice and are entitled to appear at the hearing.[87] Thus, for scrutinizing a charitable corporation's proposed asset sale, the N-PCL spells out a test to be met, the review standard for the court, and necessary and permissible parties to the proceeding.

Court approval of major changes for a not-for-profit corporation, such as a substantial asset sale, is required because a not-for-profit has fundamental structural differences from a for-profit corporation. As the *MEETH* court succinctly explained,

> in the for-profit context, shareholder power ensures that boards make provident decisions, while in the not-for-profit context, this internal check does not exist. To put it another way, a nonprofit corporation has no "owners" or private parties with a pecuniary stake to monitor and scrutinize actions by the directors. This distinction is even more significant in the case of charitable corporations, such as MEETH, where there are no members, because the board is essentially self-perpetuating.[88]

Thus, "[t]he Not-for-Profit Corporation Law addresses this lack of accountability by requiring court approval of fundamental changes in the life of a . . . charitable corporation, such as a disposition of all or substantially all assets, since there are no shareholders whose approval can be sought."[89] The *MEETH* court emphasized that the Attorney General is deemed a "statutorily necessary party" to the petition for judicial approval and that "his 'active participation' is presumed."[90] The purpose of that participation is to assure that the corporation's ultimate beneficiaries—members of the public—are adequately represented and protected "from improvident transactions."[91]

New York's N-PCL details requirements for a charitable corporation's asset sale that go beyond what most other states' nonprofit corporation statutes prescribe. Many states have enacted statutory schemes for regulating nonprofit corporations based on model legislation drafted by the American Bar Association.[92] Under the *Revised Model Nonprofit Corporation Act*, a nonprofit corporation can sell substantially all of its assets other than in the regular course of business, as would be the case for a closure of the nonprofit's operations, based principally on only board approval (and for nonprofits having members, with the members' approval).[93] Notice to the state's Attorney General of the proposed sale is required for the asset sale by a public benefit

corporation.[94] However, the *Revised Model Nonprofit Corporation Act*—and thus many states' legislation—does not expressly subject the sale to court approval as does New York's N-PCL, nor does it (or many states' laws) impose the two-part fair-and-reasonable-terms and promotion-of-corporate-purposes test set forth in New York's law.[95]

Although other states' nonprofit corporation acts do not set forth the same statutory requirements as New York's N-PCL, the principles codified in the N-PCL are derived from fundamental common-law charitable trust principles. Charitable nonprofit corporations typically exist to achieve benevolent public purposes; they generally receive tax-exempt grants and contributions, as well as other public financial support; and they commonly are exempt from federal and state taxation. As a result, charitable corporations are deemed to hold their assets in trust, being dedicated to the specific charitable purposes set forth in the corporation's charter or articles of incorporation. The public is considered to be the beneficiary of this trust, which the board members manage for the public's benefit as "trustees." Under traditional charitable trust law principles, a state Attorney General is permitted to bring an action on behalf of the public to protect these charitable assets and is entitled to represent the public interest in the sale or other transfer of the nonprofit's assets.[96]

Thus, even aside from a state's particular statutory provisions governing a charitable nonprofit's asset sale, these common-law principles mean that a nonprofit must use its assets to further its charitable purposes and that a substantial asset sale must be consistent with the nonprofit's main charitable purposes. If not, a state Attorney General can challenge the nonprofit's proposed asset sale in court. As a result, the core issues in the MEETH situation arising under New York's express N-PCL requirements could arise for a court to address in any jurisdiction when a charitable hospital wants to close or significantly change its activities through an asset sale.[97]

Despite these common-law roots to the N-PCL provisions, there are, as the *MEETH* court noted, few reported cases dealing with the approval requirements for an asset sale under New York's N-PCL.[98] The *MEETH* court thus confronted the issues arising from the proposed asset sale and closure with little case law guidance. Its decision is now the leading one in this area, which can guide parties and other courts in addressing another nonprofit's asset sale in the future.[99]

Significantly, the result in *MEETH* suggests that the business judgment rule, which substantially limits judicial review of the decisions by for-profit corporate boards, does not apply to the judicial evaluation of a nonprofit corporation's asset sale. The business judgment rule "bars judicial inquiry into actions of corporate directors taken in good faith and in the exercise of honest judgment in the lawful and legitimate furtherance of corporate purposes."[100] Generally, to overcome the business judgment rule and permit judicial scrutiny of directors' decisions, there must be a showing of fraud, bad faith, or lack of disinterested independence.[101] The business judgment rule affords a presumption of regularity to a corporate board's decisions, and courts will not second-guess corporate decisionmaking where disinterested and independent directors, on an informed basis, adopt a course of action that they honestly and reasonably believed would benefit the corporation.[102] "In essence, the business judgment rule provides that courts should not examine the quality of the directors' business decisions, but only the procedures followed in reaching that decision . . . ."[103]

New York's N-PCL requires that a not-for-profit corporation meet the two-part test for a substantial asset sale "to the satisfaction of the court."[104] While the New York cases are sparse, they explain that the courts must determine the effect of the proposed sale on the corporation's charitable purposes and whether the sale would benefit the corporation.[105] Thus, a court is authorized to protect the charitable corporation's beneficiaries "from loss through unwise bargains and from perversion of the use of the property."[106] In short, Section 511 is fairly read to give the court *de novo* review of the not-for-profit board's decision to sell all or substantially all of the corporation's assets and to empower the court to determine itself whether the proposed sale meets the two-part statutory test.

Apart from the N-PCL's language, there is sound basis for not applying the business judgment rule to a nonprofit's substantial asset sale. When a for-profit, business corporation wants to sell all or substantially all of its assets not in the regular course of business, shareholder consent generally is required under state corporate law.[107] "The purpose of the consent statutes is to protect the shareholders from fundamental change, or more specifically to protect the shareholders from the destruction of the means to accomplish the purposes or objects for which the corporation was incorporated and actually performs."[108] Furthermore, the shareholders of a for-profit corporation have ways to challenge an incumbent board of directors, or to contest board decisions like

change-of-control or substantial-asset-sale transactions: they can seek to replace management and the board through a proxy fight, start (or sell their shares in) a hostile tender offer, or bring derivative lawsuits.

But these rights and remedies available to the shareholders of for-profit, business corporations are lacking in the charitable corporation context. A main attribute of a nonprofit corporation is the absence of owners.[109] The typical charitable corporation, like MEETH, lacks even members (who might have some say in a nonprofit's decisions), so that, as the *MEETH* court observed, the nonprofit's board is entrenched, being self-perpetuating.[110] The board thus has pervasive control over a sale of the charitable corporation's assets. Indeed, the required shareholder check on a business corporation's substantial asset sale cannot exist for a charitable corporation.[111] In short, because a charitable corporation does not have shareholder-like owners with a pecuniary interest in the corporation, there generally is no outside party with a strong interest in examining and challenging the board's decisionmaking.[112]

As a result, a nonprofit board can act more freely than the usual for-profit board, being largely immune from both critical scrutiny and the conventional tools so important for policing for-profit corporations. Thus, there is much less reason to apply the hard-to-overcome presumption of regularity of board decisionmaking afforded by the business judgment rule.

While not explicitly so holding, the *MEETH* court in effect determined that the business judgment rule did not apply to a charitable corporation's asset sale. The court did not defer to the Board's decision to sell MEETH's assets, but instead thoroughly analyzed the decision itself—carefully making a *de novo* determination under the statutory criteria. Indeed, the court held that several factors derived from another state's hospital "conversion" legislation, factors that concern both the procedures and merits of a board's decision, should be considered in evaluating an asset sale under the N-PCL.[113] The court also considered the directors' duties without reference to the business judgment rule.[114] Thus the *MEETH* analysis confirmed that a court should examine the grounds for the board's sale decision, without adopting a presumption of regularity from the business judgment rule. The *MEETH* decision is further and compelling authority that the business judgment rule does not apply to the judicial process for approving or evaluating a nonprofit's asset sale.[115]

B. Considerations Under the N-PCL/Charitable Trust Law Versus the DOH Regulations

Despite some overlap, the considerations under the N-PCL and charitable trust law for judicial approval of a hospital's asset sale causing a closure differ significantly from the considerations before the DOH for regulatory approval of the closure. As a result and as occurred in the *MEETH* case, there is real potential for harmful conflicts to arise in determining whether a hospital may close.[116]

As emphasized, DOH regulatory approval for a hospital closure involves the delicate balance of protecting patients' well being in the context of state-created limits on healthcare facilities. Despite the important need to promote economic healthcare by limiting excess facilities, considerations of patient care, continuity of care, and the public health generally should be critically important to the DOH in assessing whether (and if so, how) a hospital may close.

The main purpose of judicial approval under the N-PCL, as well as under the common-law principles, is very different. It is, essentially, to protect the not-for-profit corporation as a charitable asset. This charitable asset "belongs" to no one in particular. In effect, it belongs to the whole community. Thus, the responsibility and obligation are vested with the courts, and with the Attorney General in a *parens patriae* role and by statute, to protect charitable assets for the benefit of the public.[117] After the board of a not-for-profit corporation has decided to sell all or substantially all of the corporation's assets, both the Attorney General and the courts are bound to scrutinize that decision. The ultimate approval authority is then vested in the courts, to assure that the transaction favored by the board is sound. That is, that the consideration and terms are "fair and reasonable," and, very importantly, that the transaction also meets the corporation's charitable purposes—in other words, that those purposes are "promoted" by the transaction.[118]

In the context of a hospital's asset sale, the N-PCL determination might implicate healthcare issues, but the fundamental issue is different: the Attorney General and the court must protect the charitable asset and the charitable corporate mission. Thus, the DOH's decision on closure of a hospital, albeit possibly relevant to the Attorney General and court's review, should not determine the outcome of review under the N-PCL. For example, it is possible that the DOH would permit a closure if healthcare needs are not harmed or are otherwise protected, but that an

asset-sale closure would nonetheless be impermissible under the N-PCL because it would not advance the corporation's charitable purposes. In the *MEETH* case, even though the DOH never decided the closure issue under its regulations, the Attorney General opposed MEETH's sale of assets (which necessarily would cause a closure), and the court disapproved it after trial, precisely because the proposed asset sale did not meet the N-PCL criteria.[119] While based in the statutory provision before it, the court's ruling also preserved MEETH as an important healthcare facility and assured its ability to continue its public healthcare role. In short, the considerations under the DOH regulations and the nonprofit corporation laws are intertwined, but must be considered independently.

IV. The Lessons from *MEETH*, and Some Recommendations

In the MEETH situation, a not-for-profit corporation's Board of Directors voted to close a hospital, which required regulatory approval, based upon a transaction that also required judicial approval. The Board and its administration then took steps to effectuate a closing without having obtained either regulatory or judicial approval. Despite this absence of approvals, the winding down led MEETH to the brink of an irreversible shutdown, simply from the collapse of its own operations and finances. Only aggressive, sustained, and costly opposition to closure by various parties, and diligent action by the Attorney General, prevented that from happening. But in the dynamic and rapidly changing healthcare environment, we can expect other MEETH-like situations to arise. It is therefore very important that attention be given to reconciling the dual approval process that applies when a not-for-profit medical institution wants to close, to assure that important public policy concerns are protected.

Closing a charitable hospital presents an amalgam of issues. Public health concerns—which MEETH's potential closure highlighted so forcefully—are of course vested in the DOH, as the agency with expertise over those issues. But in a MEETH-like situation in which charitable assets are also at risk, the Attorney General and, ultimately a court, have very important roles that are quite different from the DOH's. Because of the unique charitable attributes of a not-for-profit corporation, New York's legislature has determined that the judiciary (with the Attorney General's important input) bears the final decisionmaking authority over major events in the not-for-profit's life. A court must make a determination, based upon the legislative requirements,

whether a proposed transaction that might close a hospital is permissible. Because the court itself is vested with a statutorily-prescribed decision, the court need not—indeed, should not—defer to determinations made by the administrative agency, whose role and expertise involve different considerations. Simply stated, even if the DOH were to approve closing a hospital, a court might decide that the closure is impermissible under the N-PCL. And because New York's legislation comes from common-law charitable trust principles that prevail generally, the issues and problems under New York's statutory scheme and administrative regulations mirror what can occur in a closure approval process anywhere.

Achieving better reconciliation of the approval process involves the not-for-profit's board itself, more effective DOH regulations, and greater appreciation of the overriding N-PCL and charitable trust law considerations.

A. The Responsibilities of the Board

The starting point for achieving a better reconciliation of approvals is with the board of directors itself. Most states have incorporated many nonprofit corporations, and the state Attorneys General cannot effectively police even a small portion of them. (New York, for example, has about 38,000 registered charities, a number that excludes the many not-for-profits exempt from registration.) Diligent and responsible decisionmaking by their boards thus is critical. A board considering a closure should undertake—obviously without any prejudgment—an independent detailed study of the facility's operations, finances, marketplace, and the like to assist in deciding whether to close.

A decision to close should be supported by a thorough showing of justification and need, which can then be submitted to the DOH, the Attorney General, and the court. In seeking approvals, a board should be able to show that its decision is warranted, based on the most compelling circumstances, and is permissible based on public health considerations. Particularly from the public health perspective, a showing of the need to close should be thoroughly justified, as opposed to trying to achieve another course of action. In almost all cases, the analysis and advice of a truly independent, and disinterested, advisory firm or consultant will be necessary. The advisor/consultant's mandate cannot be restricted in advance and its compensation cannot be based on the nature of its recommendation. To promote the advisor/consultant being independent and disinterested, the terms of the retention should be expressly agreed upon in writing, carefully

adhered to afterwards, and disclosed at the outset. In short, both agencies (the DOH and the Attorney General) and, eventually a court will need to consider in detail *how* the board decided to close or sell assets–and the board itself should take the proper steps to establish the integrity of that decision.[120]

The MEETH situation showed how a board, without obtaining independent advice and adhering to careful consideration at the outset, could decide to close improperly. The court found it significant that the Board's retention of MEETH's original strategic advisor, who eventually recommended the assets sale, had harmed the decisionmaking process:

> [The advisor] had a direct and substantial interest in a sale of the real estate, *i.e.*, the 1% transaction fee. This arrangement . . . resulted in a situation where the Board put its reliance upon a strategic advisor which had an actual interest in the recommendations of its strategic study. It is not necessary for me to conclude that this conflict of interest compromised the result; the fee arrangement [between MEETH and the advisor] certainly gives the appearance that the integrity of the process was flawed and that the Board had not obtained the assistance of a truly independent expert. Moreover, there does not appear to have been full disclosure to the Board of the potential for a conflict of interest in the expert.[121]

Similarly, the Board's retention of healthcare consultants, who subsequently supported the Board's new clinic plan (and who were different from the original strategic advisor), was problematic, making the Board's decision further suspect. The court found it significant that these consultants were engaged months after the Board's closure decision had been made and, thus, "were charged with supporting the already decided upon plan."[122]

The failings of the MEETH Board's decisionmaking process were revealed by cross-examination at the N-PCL trial. (Even the contingency-fee-like retention of MEETH's strategic advisor evidently had not been disclosed to outside parties until the courtroom proceedings.) A trial should not be the time or place for these matters to first come to light. Without a board acting diligently and objectively at the outset, there is great potential for abuse and manipulation. A not-for-profit board needs to be attuned to these important decisionmaking issues from the start,

and it needs to approach the important decision of closing a charitable institution in an open-minded and objective way, with the aid of disinterested advisors. Indeed, to facilitate the subsequent dual approval process, the board needs to be able to demonstrate that it has done so.

In making this important decision, a core question to the board is the hospital's finances. While a charitable hospital lacks shareholders (and thus is not accountable to them for the profit expectations which face a for-profit corporation), if the hospital is continually losing money, surely something is wrong, and it might not be able to remain open. Simply put, while a not-for-profit hospital does not have the same moneymaking component of a for-profit company, it cannot be expected to survive if it remains significantly in the red.

The *MEETH* court, again cogently, answered this point. A not-for-profit corporation has a charitable mission, defined by it charter, and its board has a duty of obedience to that mission.
As the court put it:

> the duty of obedience . . . mandates that a Board, in the first instance, seek to preserve [the not-for-profit's] original mission. Embarkation upon a course of conduct which turns it away from the charity's central and well-understood mission should be a carefully chosen option of last resort. Otherwise, a Board facing difficult financial straits might find sale of its assets, and "reprioritization" of its mission to be an attractive option, rather than taking all reasonable efforts to preserve the mission which has been the object of its stewardship.[123]

When a not-for-profit hospital (or, for that matter, any nonprofit institution) confronts financial failure, *all other options* need to be evaluated fully and carefully before it abandons or even changes its mission through a complete asset sale and closure. For example, the *MEETH* case highlighted that the Board and its administration had not managed MEETH soundly and had repeatedly rejected the medical staff's recommendations for addressing the hospital's serious economic issues. Better management, enhancement of the services and business, and adaptation to marketplace changes always need to be thoroughly considered.

The *MEETH* case also highlighted—which was critical to the court—that the Board did not adequately consider various other

proposals that would have continued MEETH.[124] As eventually occurred in the MEETH situation, it is common in the healthcare industry for a financially stronger entity to take over a weaker one. Before a board ever votes for closure, it should explore every possibility of achieving a merger or acquisition that will enable another institution to carry on the failing hospital's charitable mission. Again, the *MEETH* court hit the nail on the head: "the Board has no independent vitality. It appears that the Board confused preservation of the Hospital with preservation of the Board, when the appropriate calculus should be what is good for the Hospital is good for the Board."[125]

Another important countervailing closure consideration is philanthropy. Few charitable hospitals meet their expenses based on revenue alone (and, indeed, unlike other businesses, profit admittedly is not their purpose). Philanthropy plays an important role in our healthcare system in helping hospitals make ends meet. Not surprisingly, for years before MEETH's efforts to close, its Board and administration had done little fund-raising and generally had not successfully generated charitable contributions that might have helped its finances significantly. Every conscientious not-for-profit board confronts fund-raising regularly, but for a hospital in financial difficulty, the board assuredly must be especially aggressive on this front.

It also bears emphasizing that the DOH can and should play a meaningful role in assisting a board on these countervailing closure issues. The DOH can lend some level of administrative expertise, in appropriate circumstances, to assist a beleaguered hospital administration. More significantly, the DOH can help to facilitate a merger or acquisition, or other workout-type transaction, based on its detailed knowledge of the industry and its extensive relationships with major hospitals and other healthcare providers. In MEETH's case, when it became evident that the Board was not properly considering other transactions as alternatives to closure, the medical staff urged the DOH to try to facilitate such a transaction. A conscientious board could well enlist the help of the DOH in seeking to survive, rather than just seeking the necessary approval to close.

Finally, it is very important that the board approach a sale-of-assets and closure decision rigorously and thoroughly, with careful consideration of all options, because subsequent judicial review might not apply the business judgment rule to presume that the board's decision is valid. Instead, a court might—indeed, should—review *de novo* the board's decision to close through an

asset sale. Thus, judicial review should not be limited to considering the board's procedures in adopting its decision, but would involve scrutinizing the merits and quality of the decision itself, and, particularly, whether the transaction decided upon would legitimately further the institution's charitable purposes.

The bottom line is that a not-for-profit board must recognize—as the *MEETH* court held—that closing its institution is only justifiable as a last resort, after very principled, fully-informed, and objective decisionmaking process. The *MEETH* case spelled out the many ways in which MEETH's Board did not adhere to this concept. The court's decision should be required reading for all not-for-profit boards, both in New York and elsewhere.

B. The Guidance from Administrative Regulations

The DOH needs to promulgate much better regulations governing hospital closures. The MEETH situation underscored the lack of specificity—and the resulting deficiency—of the DOH's regulations. Promulgating more explicit provisions would both better inform a hospital's board about criteria to consider in deciding whether to close and, if the board votes for a closure, what must then be done in the closing process. More explicit regulatory provisions will, of course, improve the closure approval process in other states whose regulations are, like New York's, also undeveloped.

Fundamentally, the DOH needs to ask much more than its regulations now address when confronted with a hospital closure. In the first instance, regulations should require detailed, specific, and documented findings that establish the need to close. Even more importantly, DOH regulations should also require a careful and detailed assessment of the likely effects of a closure on delivery of medical care to the community and on continuity of medical care for existing patients. Indeed, the DOH could require an impact statement, which could solicit and include the views of the public and other knowledgeable and interested parties, in assessing an application for approval to close. In the MEETH situation, the serious public health concerns from closing MEETH emerged as major issues only through an *ad hoc* campaign to inform the DOH, not as a result of compliance with DOH regulations. Regulations should also require that a hospital seeking to close must address alternatives to closure, such as merger or acquisition transactions with other institutions. If, and only if, a proposed closing complies with these regulations, then further specific regulations should spell out, in much more detail than exists presently, the concrete requirements

for actually shutting down the facility and assuring that patients' medical needs will continue to be met without interruption.

As the DOH regulations in New York now stand, the meager requirements almost presume permissibility of closing when the board seeks it: they set forth no criteria for the DOH's approval, state no requirements to be followed during the ninety-day notice period, and only briefly address a few specifics for an actual closing. The MEETH situation, once the proposed closing was finally subjected to judicial scrutiny, showed how wrong that approach is.

Also very importantly, the DOH needs to be able to freeze the status quo when confronting a closure application. That means that the DOH should not permit a hospital to wind down its operations while the closure application is pending. A winding down will invariably harm the facility significantly, causing major disruptions, dislocation, loss of patients and employees, diminution of procedures performed, and decline of the commitment of its physicians and staff—resulting, in short, in a kind of self-fulfilling prophecy leading to a shutdown. And the DOH should require the hospital to adhere to this requirement strictly, so as not to allow a hospital board and administration, having decided to close, to chip away, bit-by-bit, at the hospital's ongoing operations.

As almost happened in the MEETH situation, winding down can cause the hospital to fail *before* the DOH decides whether closure is permissible. If that occurs, the regulatory determination (as well as the judicial one) will be moot and the result assuredly will be irreversible, since once a hospital is shuttered, it is never going to be salvaged as an ongoing medical facility again.

C. The Importance of Coordinating the N-PCL and Charitable Trust Law

When closing a hospital involves an asset sale that requires review under the N-PCL, as will likely be the case, the DOH needs to work with the Attorney General to assure that the DOH's review process does not compromise the N-PCL considerations. In an asset-sale-based hospital closure, there are two policemen on the block, two regulators, both part of the executive branch of state government, who need to work together for the public good. The DOH needs to know and appreciate the Attorney General's position. There should be a constant and open dialogue between the DOH and the Attorney General about all of the issues surrounding closure, because the considerations under the N-PCL

may be intertwined with the public health issues before the DOH. Most importantly, the DOH needs to know—and appreciate the ramifications of—whether the Attorney General objects to closure based on the N-PCL criteria. For example, if the Attorney General objects to an asset-sale-based closure, the DOH needs to recognize that its consideration of closure under its regulatory authority could harm the charitable institution that the Attorney General is charged with protecting. And again, these considerations apply in any jurisdiction, because the principles embodied in the N-PCL are based on charitable trust law concepts under common law, which a state Attorney General can enforce in court.

Put simply, if the DOH gives a green light to closure based on the public health issues it considers, its doing so could destroy the charitable asset, even though the criteria under the N-PCL might not be met. And without coordination between the DOH and the Attorney General, the integrity of the judicial approval process under the N-PCL could be undermined.

In analyzing the Board's conduct, the *MEETH* court recognized the crux of this problem:

> MEETH began to act . . . upon the assumption that it would receive DOH approvals for closure and establishment of the [diagnostic and treatment] centers. It executed a letter evidencing its intent to sell to MSKCC, and chose to take steps to effectuate closure and receive regulatory approval for its plan, to enter into a contract for sale, and then to seek court approval under section 511. *This would have had the effect of presenting the court with what would have been essentially a fait accompli.* To put it another way, if everything went as-hoped-for, MEETH would have been able to present the section 511 petition pertaining to an *already* closed hospital, with DOH approval for the [diagnostic and treatment] centers, and it would have asked the court to find "that the purposes of the corporation . . . will be promoted." This would have effectively neutralized, or substantially compromised any meaningful judicial role in the section 511 process. Indeed, under the scenario envisaged by MEETH, denial of the petition would have been a pyrrhic victory for its opponents: the hospital would already be closed; under such circumstances, a court order could hardly have restored MEETH.[126]

The court's analysis of the MEETH Board's conduct was no doubt significant to its determination to disapprove the sale-of-assets contract under review. More generally, however, that analysis highlighted the potential harm from the uncoordinated dual regulatory regime that exists.

Coordination between the DOH and Attorney General in a hospital closure situation should be the norm, and achieving it should not be difficult. One sensible approach would be for the two agencies to agree upon a memorandum of understanding, or simply a written protocol of procedure, for addressing hospital closures that implicate both DOH regulations and the N-PCL.

Another significant change could be a requirement that the petition under the N-PCL be filed prior to, or at least contemporaneously with, the application under DOH regulations. DOH regulations could effectively mandate this—for example, by conditioning the DOH's consideration of a closure approval application on the applicant's contemporaneously or previously filing any required N-PCL petition. Once that petition is filed, the closure matter will be in court, and the Attorney General can appear formally to assert the public's position. Indeed, in MEETH's situation, for a significant period of time the Attorney General and the court could not address the *de facto* closure problem because there was no judicial application, but as soon as the Board finally filed its N-PCL petition, the Attorney General moved for, and the court ordered, injunctive relief to stop the Board's winding down process.

MEETH also demonstrated how the delay in filing the N-PCL petition, as the court noted, was so harmful to the hospital as a charitable institution. In particular, when the court considered the proposed asset sale, it found the sale unlawful (having tried the case and ruled very expeditiously once MEETH eventually filed its petition), but the Board's months-long winding down process preceding the filing had greatly harmed MEETH. Requiring that regulatory and judicial approvals be sought at the same time, thereby at least starting them on a concurrent time track, can help solve this problem. Significantly, requiring the not-for-profit to go to court when it also applies for DOH approval will prevent an institution from preempting the court and will allow the court to control the overall process. Thus, the court, as informed by the parties' advocacy and depending on the particular circumstances, can act to protect the charitable asset and guard against an impermissible closure, allow all interested parties to be heard, determine whether any stays or injunctive relief

are warranted, address issues of winding down if necessary, and generally regulate the often multiple and competing issues involving closure.

The coordination between the dual regulatory regimes that govern a hospital closure raises important public policy issues. While regulators could agree among themselves to coordinate the process for evaluating a closure, legislation governing a hospital's closure (as now exists in some states) is also appropriate. Legislation could prescribe the procedures for a state's Attorney General and its department of health to work together on their respective review and approval functions and specify the requirements that the hospital seeking to close must meet. More broadly, legislation could also mandate that detailed administrative regulations be promulgated to govern a proposed hospital closure; require that the healthcare issues arising from a closure be evaluated; impose a "freeze" period that could protect against a *de facto* closing; and apply provisions for protecting charitable assets and enforcing charitable trust law principles. This kind of legislation would go a long way to ameliorate the problems that became manifest in the MEETH situation.[127]

V. Conclusion

Closing a not-for-profit hospital presents numerous complex problems that intertwine serious public health issues involving the delivery of medical care and important corporate law concerns involving the preservation and appropriate disposition of a valuable charitable asset. As a result, separate regulators and different approval schemes are involved. Also as a result, closing a charitable hospital requires very disciplined and careful decisionmaking, to assure that the institution's charitable mission and public healthcare role are not short-changed. A basic lesson of the *MEETH* case—in which a renowned charitable hospital was almost lost because of flawed decisionmaking—is that the regulation and approval under the different schemes governing closure of a not-for-profit hospital must be better harmonized, so that the important public policy considerations underlying both schemes are best protected.

Endnotes

[1] Manhattan Eye, Ear, & Throat Hosp. ("*MEETH*") v. Spitzer, 715 N.Y.S.2d 575 (Sup. Ct. 1999). For commentary on *MEETH*, see Michael W. Peregrine & James R. Schwartz, *Nonprofit Corporations: The M & A Process and the Meaning of* MEETH, 28 HEALTH LAW DIGEST 3 (2000); Leo T. Crowley, *Hospital Case: Significant Governance Questions*, N.Y.L.J., Feb. 10, 2000, at 1; William Josephson, *Guiding the Way Through Changes in Charities Law*, N.Y.L.J., Sept. 18, 2000, at 1.

[2] *MEETH*, 715 N.Y.S.2d at 577.
[3] *Id.* at 581.
[4] *Id.* at 578.
[5] *Id.* at 592.
[6] *Id.* at 597.
[7] *See MEETH*, 715 N.Y.S.2d at 577.
[8] MEETH's charter stated its charitable corporate purposes as follows:

> "to establish, provide, conduct, operate and maintain a hospital in the City, County and State of New York for the general treatment of persons suffering from acute short-term illnesses; performing general plastic surgery; treating persons suffering from diseases of the eye, ear, nose or throat; and maintaining a school for post graduate instruction in the treatment of such illnesses, performing such surgery, and the treatment of such diseases, and conducting associated and basic research."

Section 5.1(a) of MEETH's Certificate of Amendment of the Certificate of Incorporation, *quoted in MEETH*, 715 N.Y.S.2d at 577.
[9] In addition to its "in-house" clinics, MEETH operates a small extension center facility in Harlem, which treats a small portion of its total clinic patients, many of whom are then referred to the hospital itself for necessary follow-up care.
[10] *MEETH*, 715 N.Y.S.2d at 577.
[11] *Id.*
[12] *Id.*
[13] *Id.* at 577.
[14] *Id.* at 578.
[15] *Id.*
[16] *MEETH*, 715 N.Y.S.2d at 579.
[17] *Id.*
[18] *Id.* at 580.
[19] *Id.*
[20] *Id.*
[21] *Id.* at 581.
[22] *MEETH*, 715 N.Y.S.2d at 581.
[23] *Id.* at 583.
[24] Randy Kennedy, *A Hospital Expands by Closing Its Doors*, N.Y. TIMES, Apr. 25, 1999, § 1, at 37.
[25] *Id.*
[26] *MEETH*, 715 N.Y.S.2d at 584.
[27] *Id.* at 585.
[28] *Id.* at 584.
[29] *Id.*
[30] As the court described the Board's conduct during late July:

> As of July 26th, the Board had neither received nor commissioned any study with regard to the Board's planned use of the sales proceeds to establish [diagnostic & treatment] centers, the necessity for such centers, or the viability of such centers. It was an idea in progress. . . . There had been no consultation with the medical staff or other medical experts or health care experts or anyone else concerning its feasibility or viability. . . .
>
> . . . .
>
> . . . Significantly, [the consultants hired on July 26] were charged with supporting the already decided upon plan. [Their] study . . . not

> unsurprisingly supported closure of the Hospital, and the transformation of MEETH from a world-class teaching hospital to operating two [diagnostic and treatment] "sites in under-served areas in Harlem and Brooklyn.". . . Neither [consultant] looked at or evaluated, or were asked to look at or evaluate, any of the proposed alternatives to closing MEETH. . . .
>
> . . . .
>
> . . . A careful evaluation of whether there was a basis for changing the corporate purposes should have determined the need to sell, not vice versa. The total absence of any study beforehand, concerning the [diagnostic and treatment] centers, and the retention of healthcare experts, only after submission of the proposal to the DOH, and only to prepare a business plan "for fulfillment" or in "support" of the D & T proposal, not to independently evaluate the plan's feasibility, buttresses the conclusion that the sale drove the change in purpose.

Id. at 586-88, 596.

[31] *Id.* at 585.

[32] *MEETH*, 715 N.Y.S.2d at 585.

[33] *See id.* at 587.

[34] *Id.*

[35] *Id.* at 585 (emphasis in original).

[36] *Id.*

[37] *Id.* at 587.

[38] *MEETH*, 715 N.Y.S.2d at 587.

[39] Shortly after learning that the Board planned to close MEETH, the medical staff, on May 10, filed a special proceeding against MEETH's individual Board members and its executive director, seeking to enjoin the proposed real estate sale and the closure of the hospital. *In re* Board of Surgeon Directors of the Manhattan Eye, Ear & Throat Hospital v. Board of Directors of the Manhattan Eye, Ear & Throat Hospital, Index No. 109692/99 (Sup. Ct. NY 1999); *see MEETH*, 715 N.Y.S.2d at 586. A group of MEETH's residents also brought a separate action arising from the termination of their employment and joined in the medical staff's special proceeding. On May 28, the same court that ultimately rejected the sale dismissed the medical staff's petition and denied the requested injunctive relief, principally for lack of standing. In its subsequent decision, the *MEETH* court noted that, while being dismissed, "the [special] proceeding demonstrated . . . that the medical staff played no role in the decision to sell and close the hospital: it was not consulted and the Board did not respond to written entreaties on behalf of the doctors," even though "it was the medical staff that distinguished MEETH." *Id.*

[40] *MEETH*, 715 N.Y.S.2d at 585.

[41] *See id.*

[42] *Id.* at 591.

[43] *Id.* at 587.

[44] *Id.*

[45] *Id.*

[46] *MEETH*, 715 N.Y.S.2d at 588-91.

[47] For a discussion of these new proposals and more details about their terms, see *id.*

[48] *Id.* at 587-88.

[49] *Id.* at 588.

[50] *Id.* at 587.

[51] The medical establishment at the national, state and local levels—the American Medical Association; the Medical Society of the State of New York; and the New York County Medical Society—also all supported preserving MEETH, as did numerous major elected government officials.

[52] *MEETH*, 715 N.Y.S.2d at 585. Once the Board decided in April to terminate the residents, their last day of employment was June 30. MEETH's residents performed many essential patient care functions in the hospital, particularly in the clinics and emergency room. Nonetheless, even shortly before June 30, the administration had made no plan to cover for residents' services come July 1. When the medical staff learned of this in late June, it immediately contacted the DOH. As a result, emergency arrangements were made, largely with the help of the medical staff and employees, to provide physician coverage for MEETH's essential medical care services after June 30.

[53] *Id.* at 588.

[54] *Id.* at 587.

[55] MEETH's directors were required to carry out their duties "in good faith and with that degree of diligence, care and skill which ordinarily prudent men would exercise under similar circumstances in like positions." N.Y. NOT-FOR-PROFIT CORP. LAW § 717(a) (McKinney 1990). The Attorney General had to move for leave to file his third-party complaint asserting breach of fiduciary duty claims because MEETH's petition commenced a special proceeding, and additional parties generally cannot be joined in a special proceeding without court permission. *See* N.Y. C.P.L.R. 401 (McKinney 1990).

[56] *MEETH*, 715 N.Y.S.2d at 577.

[57] *Id.*

[58] *Id.* at 597.

[59] *Id.*

[60] *Id.* at 595.

[61] *Id.*

[62] *MEETH*, 715 N.Y.S.2d at 595.

[63] *Id.* at 596.

[64] *Id.*

[65] *Id.* at 597.

[66] *Id.* at 594.

[67] *Id.*

[68] 541 N.E.2d 23 (N.Y. 1989).

[69] *Id.* at 28-29 (discussing DOH Regulation § 401.3(g)).

[70] *Id.* at 25.

[71] *Id.* at 27-28.

[72] *Id.* at 28.

[73] N.Y. COMP. CODES R. & REGS. tit. 10, § 401.3 (1995-1999). Title 10 of New York State's *Official Compilation of Codes, Rules & Regulations* pertains to the DOH; Part 401 governs operating certificates for medical facilities. Part 401 is promulgated under Section 2803 of the Public Health Law and was adopted in 1976.

[74] *Id.* § 401.3(g). A facility must also obtain the DOH's approval to reduce its certified bed capacity. *Id.* § 401.3(e).

[75] *Id.* § 401.3(h).

[76] *Id.* § 401.3(i).

[77] *Id.*

[78] *Id.*

[79] *See, e.g.*, FLA. ADMIN. CODE ANN. r. 59A-3.203(5) (2001) (hospital must notify state's Agency for Health Care Administration ninety days before impending closing and hospital "shall be responsible for advising the licensing agency as to the placement of patients and disposition of medical records"); ME. REV. STAT. ANN. tit. 22, § 1822 (West 1992) (person operating hospital must give

thirty days notice of voluntary closing to patients and to parties primarily responsible for patients' welfare, "so that adequate preparation may be made for the orderly transfer of said patients to another qualified facility"); MINN. STAT. ANN. § 144.555 (West 1998) (when a medical facility "voluntarily plans to cease operations," facility's controlling persons "must notify the commissioner of health at least 90 days before the scheduled cessation" and commissioner "shall cooperate with the controlling persons and advise them about relocating the patients"); OR. ADMIN. R. 333-500-0055, -0060 (2000) (closure provisions require only that if "the operation of any licensed hospital is discontinued, . . . the licensee shall notify the [state health department] of the fact in writing within 14 days of such discontinuance;" and that hospital voluntarily discontinuing operation must initiate press release notifying public of closure and stating procedure for patients to obtain medical records, and must give notice of closure and plan for disposal of records to state health department); 28 PA. CODE § 101.196 (2001) (notice of closure provision states in full: "A hospital shall give written notice of an intent to close to the Department [of Health], not later than 90 days prior to the anticipated date of closing.").

Some states have more detailed provisions concerning closure, which require some generalized assessment on delivery of healthcare to the community. *See, e.g.*, MD. CODE ANN., HEALTH-GEN. § 19-123(e)(1), (i)(1), (2) (Supp. 1999) (specifying certificate of need requirements for various hospital changes, but providing that no certificate of need is necessary for closing hospital where notice is given to public health commission and public hearing is held; or where there are few hospitals in county, commission finds that proposed closing "is not inconsistent with the state health plan or an institution-specific plan developed by the Commission" and is in the public interest). Other states now have requirements that could relate to a closing, enacted as part of recent legislation dealing with the "conversion" of a nonprofit hospital to a for-profit institution or with the sale of a nonprofit hospital's assets to another nonprofit. *See, e.g.*, R.I. GEN. LAWS § 23-17.14-18 (Supp. 1999) (under state's Hospital Conversions Act, prior to eliminating emergency department or primary care services, hospital must provide health department director with written plan that describes impact on access to and delivery of healthcare and impact on other hospitals); *cf.* ARIZ. REV. STAT. ANN. § 10-11253(F) (West 1999) (state "conversion" legislation requires public hearing concerning proposed sale/transfer, at which parties are to present information "[w]hether the intended transaction creates or has the likelihood of creating an adverse effect on the access to or availability or cost of health care services"); CAL. CORP. CODE §§ 5917(h), 5923(e) (West Supp. 2000) (under state "conversion" legislation governing sale or transfer of hospital assets, Attorney General may consider whether "[t]he agreement or transaction may create a significant effect on the availability or accessibility of health care services to the affected community").

[80] *See* Levine v. Whalen, 384 N.Y.S.2d 721 (1976) (while statutory authority sufficiently sets standards for DOH to promulgate regulations, certain DOH regulations themselves, which were based on requirements specified by DOH Commissioner, were impermissibly vague and subjective); Slocum v. Berman, 439 N.Y.S.2d 967, 970 (App. Div. 1981) (DOH regulations, modified in light of prior cases, upheld as not impermissibly vague and subjective; "[t]he standard whereby the sufficiency of the statute or regulation is measured is whether men of common intelligence must necessarily guess at what conduct is prohibited"); Koelbl v. Whalen, 406 N.Y.S.2d 621, 623 (App. Div. 1978) (certain DOH regulations were impermissible because they "impose[d] no objective standard, but ultimately require[d] the facilities and

services to meet the 'approval' or 'satisfaction' of the Commissioner," or were "subjective and, therefore, invalid"). *See generally* 1 MICHAEL G. MACDONALD ET AL., TREATISE ON HEALTH CARE LAW § 4.03[6][a] (2000).

[81] *MEETH*, 715 N.Y.S.2d at 585.

[82] Of particular significance, for example, was access to adequate substitute care for the 80,000 to 90,000 annual patient visits provided through MEETH's clinics; much of this care is for elderly and indigent patients with serious vision, hearing, and other ENT problems that required highly specialized treatment and continuing care and monitoring. Another important concern was the availability of emergency care in MEETH's specialty fields.

[83] The N-PCL provides for four types of not-for-profit corporations, defined by the purposes for which the corporation is formed. N.Y. NOT-FOR-PROFIT CORP. LAW § 201 (McKinney 1990). MEETH is a "Type B" corporation—a charitable not-for-profit—under N-PCL § 201(b). The "Type B" corporation is the traditional charitable organization, which can qualify for a federal tax exemption under Section 501(c)(3) of the Internal Revenue Code. However, not all nonprofit corporations are charitable corporations; for example, trade associations, unions, business organizations and civic, political and fraternal groups might exist as nonprofit corporations or organizations. This Article generally uses "nonprofit" or "not-for-profit" to refer only to charitable nonprofit corporations.

[84] N.Y. NOT-FOR-PROFIT CORP. LAW §§ 510-511.

[85] *Id.* § 511(d); *see MEETH*, 715 N.Y.S.2d at 576, 591-92. If the charitable corporation has members, the second prong of the test includes whether the sale will promote "the interests of the members."

[86] N.Y. NOT-FOR-PROFIT CORP. LAW § 511(d).

[87] *Id.* § 511(b). In addition to requiring notice to the Attorney General, Section 511(b) states that the court, in its discretion, shall direct that notice of the petition be given "to any person interested therein, as member, officer or creditor of the corporation"; and it also provides that "[a]ny person interested, whether or not formally notified, may appear at the hearing" and contest the petition for approval. Those provisions are fairly read to permit the participation of any party interested in the proposed asset sale (not just participation of a member, officer, or creditor of the not-for-profit). As noted, several interested parties were permitted to join in the *MEETH* litigation, and they participated fully in the trial; most did not fall within the discrete categories of members, officers, or creditors of MEETH. Like the other elements of the N-PCL provisions relating to an asset sale, this intervention-like provision has common-law roots. *See* 4A AUSTIN W. SCOTT & WILLIAM F. FRATCHER, THE LAW OF TRUSTS § 391, at 379 (4th ed. 1989).

[88] *MEETH*, 715 N.Y.S.2d at 592.

[89] *Id.*

[90] *Id.*

[91] *Id.* at 592-93 (citing Rose Ocko Found., Inc. v. Lebovits, 686 N.Y.S.2d 861, 864 (App. Div. 1999)). *See also* VICTORIA B. BJORKLUND ET AL., NEW YORK NONPROFIT LAW AND PRACTICE: WITH TAX ANALYSIS § 8-2(a), at 238 (1997):

> What the law seeks to do in each case, consistent with New York's *quasi-cy pres* doctrine, is to preserve charitable assets to serve public purposes. This is assumed, in each case, by making these transactions subject to court approval, on notice to and, presumably, with the active participation of the Attorney General, and because these are transforming events, to require board and member approval when there are members.

[92] Numerous states' laws regulating nonprofit and charitable corporations are based either on the MODEL NONPROFIT CORPORATION ACT (promulgated in 1952) or the subsequent REVISED MODEL NONPROFIT CORPORATION ACT (adopted in 1987). However, the states often have adopted their own extensive variations to the model legislation, so that even among states that follow the model laws, provisions differ significantly. *See* 1 MARILYN E. PHELAN, NONPROFIT ENTERPRISES: LAW AND TAXATION § 1:11 (1995). Other states, particularly New York and California, have unique nonprofit corporation acts that differ substantially from the model acts. *Id.* at note 2. For a summary of all the states' nonprofit corporation acts, see *id.* §§ 1:12-1:62.

[93] REVISED MODEL NONPROFIT CORPORATION ACT § 12.02 (1987). Specifically, if the nonprofit does not have any members, such an asset sale can be authorized by the approval of a majority vote of the directors. *Id.* § 12.02(c). For a nonprofit with members, the transaction is permissible if it is approved by the board, by a members' vote of two-thirds of the votes cast or a majority of voting power, and by any person whose approval is specifically required under the corporation's articles of incorporation or bylaws. *Id.* § 12.02 (a)-(b).

[94] *Id.* § 12.02(g) (1987). A public benefit corporation includes corporations with the charitable-entity federal tax exemption under Section 501(c)(3) of the Internal Revenue Code, as well as corporations organized for public or charitable purposes. *See id.* §§ 1.40(28), 17.07. Some states adopt this notice-to-the-Attorney-General provision for an asset sale in their nonprofit corporation acts. *See, e.g.*, CAL. CORP. CODE § 5913 (West Supp. 2000); MASS GEN. LAWS ANN. ch. 180, § 8A (West 1998); TENN. CODE ANN. § 48-62-102(g) (1995). Other states, even after adopting a sale of assets statute that generally tracks the Revised Act, nonetheless omit this notice provision. *See, e.g.*, CONN. GEN. STAT. ANN. § 33-1166 (West 1997); FLA. STAT. ANN. §§ 617.1201, 617.1202 (West 1993); 805 ILL. COMP. STAT. ANN. § 105/111.60 (West 1993); N.J. STAT. ANN. § 15A:10-11 (West 1984); TEX. REV. CIV. STAT. ANN. art. 1396-5.09 (West 1997); WIS. STAT. ANN. § 181.1202 (West Supp. 1999). *Cf.* OHIO REV. CODE. ANN. § 1715.39 (Anderson 1997) (requiring court approval for charitable organization's proposed sale or other disposition of real estate).

[95] In addition to the regulation of asset sales by all nonprofit corporations, in recent years many states have enacted legislation dealing specifically with asset sales that involve the "conversion" of nonprofit healthcare facilities into for-profit institutions. As the *MEETH* court observed, while these conversions are not permitted in New York, there has been a "nationwide spate" of such conversions, which has generated much commentary. *See* 715 N.Y.S.2d at 593. (citations omitted). For a compilation of legislation regulating hospital conversions (enacted as of recently in 16 states and the District of Columbia), see *The Sale and Conversion of Not-For-Profit Hospitals: A State-by-State Analysis of New Legislation* (1998) (publication available from the Volunteer Trustees Foundation for Research and Education, Washington, D.C.). For a discussion of nonprofit hospital conversions generally, see James J. Fishman, *The Checkpoints on the Conversion Highway: Some Trouble Spots in the Conversion of Nonprofit Health Care Organizations to For-Profit Status*, 23 J. CORP. L. 701 (1998); David A. Hyman, *Hospital Conversions: Fact, Fantasy, and Regulatory Follies*, 23 J. CORP. L. 741 (1998).

Discussion of this conversion legislation is generally beyond the scope of this Article. However, it is worthwhile to note California's approach. California has longstanding legislation dealing with substantial asset sales by all nonprofit corporations, which requires notice to the Attorney General. Recently, California also enacted separate legislation governing an asset sale by a nonprofit health facility to both a for-profit corporation (enacted in 1996), *see* CAL. CORP. CODE §§ 5914-19 (West Supp. 2000), and to another

nonprofit corporation. *Id.* §§ 5920-25 (enacted in 1999). (Several other states' hospital conversion laws also cover nonprofit-to-nonprofit asset transfers. *See The Sale and Conversion of Not-For-Profit Hospitals, supra* at 3.) California's laws require notice of the health facility's proposed transaction to California's Attorney General and the Attorney General's written consent to it, CAL. CORP. CODE §§ 5914, 5920, and they set forth factors that the Attorney General may consider that are akin to New York's N-PCL test. *Id.* §§ 5917, 5923. Significantly, because this legislation specifically addresses a health facility's asset sale, the Attorney General may consider whether "[t]he agreement or transaction may create a significant effect on the availability or accessibility of health care services to the affected community." *Id.* §§ 5917(h), 5923(e).

[96] RESTATEMENT (SECOND) OF TRUSTS § 348 & comment f, § 391 (1957); SCOTT & FRATCHER, *supra* note 87, § 348, at 7, § 348.1, at 9, 15, § 379, at 315-16, § 391, at 357, 360-61; *see also* Mary Grace Blasko et al., *Standing to Sue in the Charitable Sector*, 28 U.S.F. L. REV. 37, 42-47 (1993); Lawrence E. Singer, *The Conversion Conundrum: The State and Federal Response To Hospitals: Changes in Charitable Status*, 23 AM. J.L. & MED. 221, 237-38 (1997); Philip M. Gassel & Jay E. Gerzog, *Conversions of Not-for-Profit Organizations Proliferate*, NAT'L. L.J., Aug. 26, 1996. *Cf.* RESTATEMENT (SECOND) OF TRUSTS § 372 (1957) ("A trust for the promotion of health is charitable."); Fishman, *supra* note 95, at 703 ("From the time of the Elizabethan Statute of Uses [in 1601], the promotion of health has been considered a charitable purpose . . . .").

[97] *See* Greil Mem'l Hosp. v. First Alabama Bank, 387 So. 2d 778 (Ala. 1980) (parties sought right to will bequest made to charitable hospital, after hospital changed its original sole purpose of treating tuberculosis to become grant-making foundation funding various projects; court held that bequest lapsed when recipient hospital changed its sole corporate purpose, since bequest was gift in trust for that purpose); Holt v. College of Osteopathic Physicians & Surgeons, 394 P.2d. 932 (Cal. 1964) (plaintiffs sought to enjoin, as diversion of assets, nonprofit trustees' plan to change osteopathic medical college to allopathic medical school; court upheld cause of action for threatened breach of charitable trust, because complaint sufficiently alleged acts not within the nonprofit's charitable purpose); Queen of Angels Hosp. v. Younger, 136 Cal. Rptr. 36 (Ct. App. 1977) (nonprofit hospital could not lease its property and then use lease proceeds to establish outpatient clinics which were not equivalent to a hospital; court accepted Attorney General's argument that using those assets exclusively for outpatient clinics would be an abandonment of nonprofit's primary charitable purpose and an impermissible diversion of charitable trust assets); Attorney General v. Hahnemann Hosp., 494 N.E.2d 1011 (Mass. 1986) (Attorney General sought to enjoin nonprofit hospital's sale of all its assets to for-profit hospital; court held that even though board had amended charter to change corporate purposes, nonprofit could not use the sale proceeds for these new purposes because doing so would violate terms of a trust which had provided the hospital's original funding and whose terms were incorporated in the hospital's bylaws); Taylor v. Baldwin, 247 S.W.2d 741 (Mo. 1952) (Attorney General sought to enjoin charitable hospital from affiliating with and relocating at university medical center, asserting violation of hospital's charter as well as of certain gifts and trusts; stating that courts should not interfere with nonprofit board's decision unless there is "substantial departure" from the charity's "dominant purpose," court permitted affiliation and relocation because hospital would continue to fulfill and not depart from its specified charitable purposes under affiliation/relocation); City of Paterson v. Paterson Gen. Hosp., 235 A.2d 487 (N.J. Super. Ct. Ch. Div. 1967) (plaintiffs sought to prevent charitable hospital from relocating to adjacent community

because hospital's charter stated that hospital was to be located within city of Paterson; court upheld board's decision to relocate because residents would have continued access to the hospital, sound evidence supported need to move, and move did not constitute a "substantial departure" from corporate purposes). *See also* Bossen v. Woman's Christian Nat'l Library Ass'n, 225 S.W.2d 336 (Ark. 1949) (nonprofit permitted to sell land held in charitable trust for library purposes because it was unable to use land for those purposes but could use proceeds of sale to build new library at another site); Riverton Area Fire Prot. Dist. v. Riverton Volunteer Fire Dep't, 566 N.E.2d 1015 (Ill. App. Ct. 1991) (Attorney General and others sued to prevent nonprofit corporation fire department from selling its assets after corporation changed its corporate purposes; court affirmed judgment for Attorney General, emphasizing that nonprofit held its assets as trustee of charitable trust and that because nonprofit changed its purposes, assets should be delivered to another party to continue their use for original charitable purposes).

[98] *MEETH*, 715 N.Y.S.2d at 592.

[99] Departing from the statutory and common-law standards, one commentator has argued that only the sale price should be considered, asserting that a nonprofit board selling its corporation's assets in a change-of-control transaction has a duty to accept the highest bid offered. Colin T. Moran, *Why* Revlon *Applies to Nonprofit Corporations*, 53 BUS. LAW. 373 (1998). This argument derives from a well-known corporate law case, Revlon, Inc. v. MacAndrews & Forbes Holdings, Inc., 506 A.2d 173 (Del. 1986). *Revlon* held that the board of a for-profit corporation undertaking a change-of-control or break-up sale of the corporation should perform an auction-like market check on price to maximize value to the shareholders, so that generally the board has a duty to accept the highest price offered. The argument runs that *Revlon* should be applied even to the sale of a nonprofit corporation. This position mainly rejects the notion that a bidder's commitment to the nonprofit's charitable purposes would justify the board's accepting a lower purchase price; the contention is that "[d]eferring to a board's 'charitable purpose' for accepting a low bid . . . leaves any board free to accept whatever deal it chooses"—and that nonprofit boards and the courts cannot be relied upon to determine whether the charitable attributes of a low bidder and a commitment to continue the nonprofit's charitable purposes justify the lower price. Moran, *supra*, at 388-89. (The article nonetheless notes that no court has yet applied *Revlon* to nonprofits and that other commentary has not advocated doing so; *id.* at 375.) The argument, in effect, is that at least so long as some protections are implemented to safeguard the corporation's charitable purposes, the highest offer necessarily is the best transaction for a nonprofit corporation undertaking to sell its assets.

The *MEETH* case showed the error of this theoretical argument. Under New York's N-PCL, as well as under common-law charitable trust principles, whether a proposed asset sale promotes the nonprofit corporation's charitable purposes is fundamental to the permissibility of the sale. This determination inherently involves more than a pure monetary valuation of assets. In evaluating the MEETH Board's proposed asset sale, the court rejected the proposition that only price mattered. Indeed, obtaining a high purchase price—and seeking to "monetize" MEETH's assets—did not assure integrity of the Board's decision; instead, doing so led the Board to abandon MEETH's long-established corporate purposes. MEETH's Board thus proposed a transaction that did not promote MEETH's charitable purposes but instead would have involved very different purposes. While the highest offer that does promote a nonprofit's charitable purposes should, of course, be the preferred transaction, there must be very careful scrutiny to assure that the proposed

transaction does, in fact, promote the required charitable purposes. The *MEETH* case illustrated the problem: the Board *contended* that its proposed transaction—which would have closed MEETH as a hospital, then using the asset-sale proceeds to establish new clinics—promoted MEETH's corporate purposes; however, when that transaction was scrutinized, the court found that it really did not do so. Importantly, *MEETH* demonstrated that a court, through the regular trial process, is fully able to evaluate the competing transactions for acquiring a nonprofit corporation and whether a proposed transaction furthers the nonprofit's charitable purposes. *See* Fishman, *supra* note 95, at 720-21 ("In the nonprofit context the board's responsibilities should be to maximize the return to the public, including benefits to the community. This does not necessarily mean that the board must accept the highest price." Fishman also contends that board's business judgment applies to acceptance of a bidder.).

[100] Auerbach v. Bennett, 47 N.Y.2d 619, 629 (1979); *see* Levandusky v. One Fifth Ave. Apartment Corp., 75 N.Y.2d 530, 537-38 (1990). *Accord* Smith v. Van Gorkom, 488 A.2d 858, 872 (Del. 1985); Aronson v. Lewis, 473 A.2d 805, 812 (Del. 1984) (The business judgment rule is "a presumption that in making a business decision the directors of a corporation acted on an informed basis, in good faith and in the honest belief that the action taken was in the best interests of the company."). While the courts of other states may explain or state the business judgment rule using somewhat different language, the formulation and application are essentially the same as in New York and Delaware. *See* 1 WILLIAM E. KNEPPER & DAN A. BAILEY, LIABILITY OF CORPORATE OFFICERS AND DIRECTORS § 2-1, at 48 (6th ed. 1998).

[101] *Auerbach*, 47 N.Y.2d at 631.

[102] *See* 1 DENNIS J. BLOCK, ET AL., THE BUSINESS JUDGMENT RULE: FIDUCIARY DUTIES OF CORPORATE DIRECTORS 4-6 (5th ed. 1998).

[103] KNEPPER & BAILEY, *supra* note 100, § 2-1, at 47.

[104] N.Y. NOT-FOR-PROFIT CORP. LAW § 511 (d) (McKinney's 1990).

[105] *See In re* Agudist Council v. Imperial Sales Co., 551 N.Y.S.2d 955, 957 (App. Div. 1990); Church of God of Prospect Plaza v. Fourth Church of Christ, Scientist, 431 N.Y.S.2d 834, 838 (App. Div. 1980), *aff'd*, 442 N.Y.S.2d 986 (1981); Manhattan Threatre Club, Inc. v. Bohemian Benevolent & Literary Ass'n, 467 N.Y.S.2d 143, 146 (Sup. Ct. 1983), *aff'd*, 478 N.Y.S.2d 274 (App. Div. 1984), *aff'd*, 489 N.Y.S.2d 877 (1985).

[106] Rose Ocko Found., Inc. v. Lebovits, 686 N.Y.S.2d 861, 864 (App. Div.) (citation omitted), *appeal dismissed and mot. for leave to appeal denied*, 696 N.Y.S.2d 107 (1999). *See* N.Y. NOT-FOR-PROFIT CORP. LAW § 511 (McKinney 1997) ("Generally, each court will decide on a case by case basis whether the contract is in the best interest of the corporation.").

[107] 6A WILLIAM MEADE FLETCHER ET AL., FLETCHER CYCLOPEDIA OF THE LAW OF PRIVATE CORPORATIONS § 2949.20.10 (perm. ed. rev. vol.1997) ("Every state requires in some or all instances where all, or substantially all, of the corporate assets are sold or transferred that there be shareholder consent."). *See, e.g.*, N.Y. BUS.CORP. LAW § 909 (McKinney 1986 & Supp. 2000).

[108] 6A FLETCHER, *supra* note 107, § 2949.20.10. Indeed, in determining whether a sale constitutes "all or substantially all" of the assets of a corporation, courts look to whether "the fundamental purpose for which the corporation was formed was eliminated as a result of the transfer." *Id.* § 2949.40.

[109] *MEETH*, 715 N.Y.S.2d at 592.

[110] *Id.*

[111] *Id.*

[112] *Id.*

[113] *Id.* at 594 (employing factors enumerated in the Nebraska statute, as summarized in Mark Krause, *"First, Do No Harm": An Analysis of the Nonprofit Hospital Sale Acts*, 45 UCLA L. REV. 503, 550 (1997)).

[114] *See MEETH*, 715 N.Y.S.2d at 593.

[115] It has been noted that confusion exists in regulating nonprofit hospital sales within various jurisdictions because nonprofit hospitals are governed by both statutory corporate law and charitable trust law; thus, commentary has observed a "modern trend" from certain jurisdictions to apply corporate fiduciary standards rather than generally more rigorous trust principles to gauge nonprofit directors' duties–so that the business judgment rule would apply to nonprofit directors' decisions involving nonprofit hospital sales. *See* KNEPPER & BAILEY, *supra* note 100, § 12-2(b), at 418-19; Rachel B. Rubin, *Nonprofit Hospital Conversions in Kansas: The Kansas Attorney General Should Regulate All Nonprofit Hospital Sales*, 47 U. KAN. L. REV. 521, 536-49 (1999). *See also* Stern v. Lucy Webb Hayes Nat'l Training Sch., 381 F. Supp 1003, 1013 (D.D.C. 1974). The model nonprofit legislation accepts the business judgment rule and rejects the stricter trustee standard of care. REVISED MODEL NONPROFIT CORP. ACT § 8.30 & cmt 3 (1987) ("While the application of the business judgment rule to directors of nonprofit corporations is not firmly established by the case law, its use is consistent with section 8.30 [setting forth general standards of conduct for directors of a nonprofit corporation]."); *id.* § 8.30(e) ("A director shall not be deemed to be a trustee with respect to the corporation or with respect to any property held or administered by the corporation . . . ."). *See* Fishman, *supra* note 95, at 735-39 (recognizing business judgment rule for nonprofit decisionmaking but recommending enhanced scrutiny for conversion transactions); Harvey J. Goldschmid, *The Fiduciary Duties of Nonprofit Dirs. and Officers: Paradoxes, Problems, and Proposed Reforms*, 23 J. Corp. L. 631, 648-51 (1998) (recommending judicial review more rigorous than business judgment rule, such as a fairness test, for matters implicating nonprofit directors' duty of loyalty, like interested-director transactions; but suggesting business judgment rule should apply for conversions and similar transactions).

Nonetheless, New York's statutory scheme governing a not-for-profit's asset sale specifies, in straightforward language, that the two-part test must be met "to the satisfaction of the court." As a result, the *MEETH* court emphasized that its "mandate" under the N-PCL was to review the proposed sale to assure that the interests of the public, as the corporation's ultimate beneficiaries, are "protected from improvident transactions." *MEETH*, 715 N.Y.S.2d at 592-93. Such judicial review precludes justifying a sale solely under the business judgment rule. While MEETH's Board initially argued that the business judgment rule applied to its sale decision, it did not pursue that contention, effectively abandoning it by the end of the trial. (In any event, the facts in *MEETH* probably would have overcome even the protection afforded by the business judgment rule.) And aside from the N-PCL express language, there are, as discussed above, valid reasons why a court should not apply the business judgment rule in evaluating any nonprofit board's sale-of-assets decision.

[116] In New York, virtually all hospitals (other than public hospitals organized and operated through government or government-like agencies) exist as charitable corporations. The reason for this is that the statutory provisions by which New York permits a hospital to be established effectively prohibit a public for-profit company from owning a hospital. *See* N.Y. PUB. HEALTH LAW § 2801-a (McKinney Supp. 2000); *see also* Gassel & Gerzog, *supra* note 96; Hyman, *supra* note 95, at 766. As a result, a New York hospital that wants to sell all or substantially all of its assets as part of a closure plan (or which will cause a closure) will likely need judicial approval for the transaction under the N-PCL; thus, the problems so manifest in MEETH's situation will reoccur.

[117]In addition to approval for a substantial assets sale, a petition for judicial approval, with notice to the Attorney General, is required for numerous other significant corporate changes by a New York not-for-profit corporation, such as merger and dissolution (*see* N-PCL Articles 9, 10 & 11) and amendment of corporate purposes. (*See* N.Y. NOT-FOR-PROFIT CORP. LAW § 804(a).) With regard to the Attorney General's statutory authority, see N.Y. NOT-FOR-PROFIT CORP. LAW §§ 112(a), 720(b) (right to bring lawsuit); N.Y. EST. POWERS & TRUSTS LAW §§ 8-1.1, 8-1.4 (McKinney 1992 & Supp. 2000) (relating to disposition and supervision for charitable trusts); N.Y. EXEC. LAW § 63 (McKinney 1993 & Supp. 2000) (general duties of Attorney General, including duty to prosecute and defend actions in which state is interested).

[118]*MEETH*, 715 N.Y.S.2d at 591-92.

[119]*Id.* at 592.

[120]The *MEETH* court noted that the process of converting a not-for-profit hospital into a for-profit hospital was "analytically useful" to the N-PCL determination before it. The court thus found that several of the factors from another state's hospital conversion legislation should be considered in the N-PCL determination: (a) whether the not-for-profit used due diligence in deciding to sell, selecting the purchaser and negotiating the sale's terms and conditions; (b) whether the procedures used in making the sale decision, including whether an appropriate expert was used, were fair; (c) whether conflicts of interest (including that of board members or retained experts) were disclosed; and (d) whether the hospital will receive reasonably fair value for its assets. *MEETH*, 715 N.Y.S.2d at 594. These factors go to the integrity of the board's decision, and they should be foremost in the board members' minds as they go about their decisionmaking process

[121]*MEETH*, 715 N.Y.S.2d at 595-96.

[122]*Id.* at 586.

[123]*Id.* at 595.

[124]*Id.* at 596.

[125]*Id.*

[126]*Id.* at 586 (first emphasis added).

[127]Various states' conversion legislation may be instructive for coordinating regulation. California's statutes provide that the Attorney General must review the conversion transaction but do not require direct review by the state Department of Health Services. Rather, the Attorney General is authorized to seek assistance from any state agency (which would include the Department of Health Services), as he or she "deems appropriate." *See* CAL. CORP. CODE §§ 5919, 5924 (West Supp. 2000). Review by the Department of Health Services was included in an earlier version of a California conversion bill but evidently was eliminated because the bill's sponsors decided that another level of review would overly burden the conversion process. *See* Mark Krause, *"First, Do No Harm": An Analysis of the Nonprofit Hospital Sale Acts*, 45 UCLA L. REV. 503, 550 (1997). Taking a different approach, another state's statute dealing with these conversions *requires* Department of Health review, mandating it to consider healthcare issues. NEB. REV. STAT. §§ 71-20,107, 71-20,109 (1996); *see* Krause, *supra*, at 551. Yet another state's statute regulating nonprofit hospital sales provides that *the Attorney General*, as part of his or her evaluation of the transaction, should consider whether the proposed transaction has sufficient safeguards "to assure the affected community continued access to affordable care" and to protect other health-care related concerns. *See* LA. REV. STAT. ANN. § 40:2115.18 (West Supp. 2000). Legislation could be crafted that gives both the state's Attorney General and its public health department significant input and authority, with each agency using its particular expertise, into the determination whether a charitable hospital may close.