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CORRIDORS

News for North Carolina Hospitals
from the Health Law Attorneys of Poyner Spruill LLP

RECENT DECISION HIGHLIGHTS POTENTIAL PERSONAL LIABILITY OF HOSPITAL DIRECTORS BASED ON BREACH OF FIDUCIARY DUTY

by Wilson Hayman

In a recent case, a federal bankruptcy court in Michigan reviewed important questions involving breach of fiduciary duty and the application of the business judgment rule to both management and volunteer board members of a nonprofit hospital. In that case, the liquidating trust for bankrupt Cheboygan Memorial Hospital filed a lawsuit alleging negligence and/or breach of fiduciary duty by the former officers and directors of the hospital. The trust claimed that defendants had failed to address losses from its employed physician practices; failed to address billing and coding issues; failed to ensure adequate control over financial issues allowing the financial statements to overstate the hospital's revenues; improperly approved the quick sale of a joint venture home health agency for less than fair market value in order to meet payroll; allowed excessive senior management turnover to continue; permitted excessive compensation to physician board members; and allowed a conflict of interest when the hospital refinanced $4.3 million in long-term debt with a bank whose president was a hospital director. *CMH Liquidating Trust v. Anderson*, Case No. 12-20666, Chapter 11, Adversary Proceeding No. 14-02020 (August 2, 2018).

Michigan Bankruptcy Court Decision. In ruling on the defendants' motion to dismiss, the court dismissed certain claims but also found that the plaintiff had stated sufficient facts to proceed against the hospital's interim CEO and five directors. The court found that one director had a conflict between her role as a director and service as president of the bank which loaned the hospital money, and that a physician director was not disinterested because he received excessive compensation for his board service. In addition, the court permitted the case to proceed against three other directors whom the plaintiff alleged were not volunteer directors. These directors all allegedly served on the board at the time of the sale of the joint venture and allowed the payments to be made to the bank. The court dismissed all claims against the other volunteer directors, holding they were immune from liability based on certain exculpatory language in the hospital's articles of incorporation, as permitted by Michigan statute.

The court reviewed the business judgment rule, which creates a presumption that in making a business decision, directors of a corporation are protected if they acted on an informed basis, in good faith, and with the belief that the action was in the best interests of the company. However, this rule only protects disinterested directors. Moreover, if the plaintiff can show that defendants were given actual notice of the need to take action, this rule provides no protection where directors have abdicated their authority or simply failed to act.

North Carolina Law. Although the North Carolina Nonprofit Corporation Act (the Act), at N.C. Gen. Stat. § 55A, does not use the word "fiduciary" – which was removed to avoid potential confusion between the fiduciary standards applicable under trust law and those in corporate law – the Act imposes the duties of good faith, loyalty, and due care on directors. Like the relevant Michigan statute in *CMH Liquidating Trust*, the Act requires the directors of a nonprofit corporation to discharge their duties as a director and a committee member:

- in good faith;
- with the care an ordinarily prudent person in a like position would exercise under similar circumstances; and
- in a manner the director reasonably believes to be in the best interests of the corporation.

A director is generally entitled to rely upon information and reports prepared or presented by officers and employees of the corporation, legal counsel or accountants, and board committees if the director reasonably believes they are reliable and competent in the matters presented, unless the director has actual knowledge that makes such reliance unwarranted. Consequently, directors of a nonprofit hospital may not serve as a mere figurehead; instead, they must affirmatively exercise due care in fulfilling their duties as director.

The Act contains a number of provisions which address potential liability of directors. A director shall have no personal liability for any

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TITLE IX - A NEW PATHWAY FOR SEX DISCRIMINATION CLAIMS BY MEDICAL RESIDENTS?

by Brett Carpenter

Title IX of the Education Amendments of 1972, 20 U.S.C. § 1681 *et seq.* (Title IX) has received a lot of attention recently for its impact on college athletic programs. Both male and female sports have grown increasingly popular and can now create large revenue streams for their educational institutions. With all the focus on sports, many people outside of the legal arena probably overlook that Title IX actually covers *all* aspects of education. For example, a federal appellate court held just last year that the discrimination and harassment prohibitions of Title IX even extend to medical residency programs in private hospitals.

Under that ruling, a medical resident was allowed to sue her hospital-employer for sex discrimination directly under Title IX without wading through the traditional administrative prerequisites to filing suit under Title VII of the Civil Rights Act of 1964, 42 U.S.C. §§ 2000e, *et seq.* (Title VII) – the statute most employees rely on for sex discrimination claims. Bypassing Title VII's administrative prerequisites not only makes it easier for an employee to sue, but also extends the time in which an employee can bring suit. Title IX's lack of such prerequisites allows direct access to federal courts and could mean an uptick of employment lawsuits brought by medical residents against private hospitals. Consequently, hospitals and other medical facilities with residency programs should ensure they understand their obligations under Title IX and remain vigilant in their efforts to prevent sexual harassment, discrimination, and retaliation.

Application of Title IX. Title IX was passed in 1972 to prevent federal money from funding education programs that engage in sex discrimination. The law provides, with certain exceptions, that "[n]o person in the United States shall, *on the basis of sex*, be excluded from participation in, be denied the benefits of, or be subjected to discrimination *under any education program or activity receiving Federal financial assistance*." Title IX prohibits sex discrimination in a broad spectrum of employment actions, such as, recruiting, advertising, applying, hiring, upgrading, promoting, considering for and awarding of tenure, demoting, transferring, rehiring, assigning jobs, and granting leaves of absence.

The express enforcement mechanism under Title IX is an administrative procedure for withdrawal of federal funding from noncompliant programs, but the United States Supreme Court has instructed that an implied private right of action also exists for injunctive relief and damages. As mentioned, last year, the United States Court of Appeals for the Third Circuit (jurisdiction over Delaware, New Jersey, Pennsylvania, and the Virgin Islands) held in *Doe v. Mercy Catholic Medical Center*, 850 F.3d 545 (3d Cir. 2017), that Title IX authorizes a medical resident to sue her private hospital-employer for sex discrimination and harassment. The *Mercy* Court ruled that the residency program at issue constituted an "education program or activity" covered by Title IX because (1) it was certified by the Accreditation Council for Graduate Medical Education, meaning the hospital's mission was, at least in part, education, (2) the hospital required its residents to participate in lectures, give presentations, and sit for exams, (3) the hospital appeared to hold out its residency program as educational in nature, and (4) the residency program was sponsored by Drexel University's College of Medicine.

The hospital argued for the first time on appeal that it did not receive "Federal financial assistance" under Title IX because its Medicare payments stem from "contracts of insurance," but the *Mercy* Court declined to consider this argument. Instead, the *Mercy* Court assumed, without deciding, that the hospital's receipt of Medicare payments satisfied Title IX's requirement that the education program or activity (i.e., the residency program) receives "Federal financial assistance," thus bringing it under the purview of Title IX. The *Mercy* Court went on to explain that the resident-employee's Title IX claims were not precluded by Title VII, even though the two statutes could both be applicable for claims of sexual harassment, discrimination, and retaliation filed by the medical resident-employee. Significantly, not every court to consider that issue has sided with the *Mercy* Court's conclusion. Under similar facts, a Texas trial court concluded that Title VII provides the *exclusive remedy* for a medical resident seeking relief for sexual harassment and retaliation claims against their hospital-employer.

Although the United States Court of Appeals for the Fourth Circuit (jurisdiction over North Carolina, South Carolina, Virginia, West Virginia, and Maryland) has yet to decide if a medical residency program is subject to Title IX, in *Preston v. Virginia ex rel. New River Cmty. Coll.*, 31 F.3d 203, 206 (4th Cir. 1994), that court allowed an employee to sue his/her employer under Title IX for alleged gender discrimination, suggesting that such private causes of action are not preempted by Title VII in this state. Specifically, the *Preston* Court explained that Title IX's implied private right of action "extends to employment discrimination on the basis of gender by educational institutions receiving federal funds," and that "[r]etaliation against an employee for filing a claim of gender discrimination is prohibited under Title IX."

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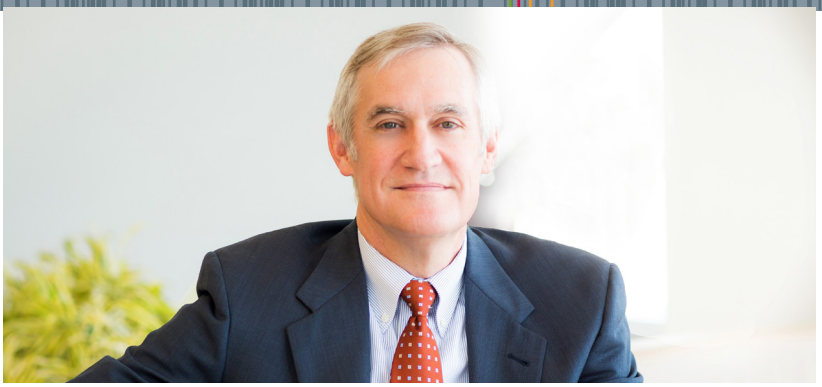

PROPOSED 2019 SMFP NEED DETERMINATIONS

by S. Todd Hemphill

Effective July 1, 2018, the State Health Coordinating Council (SHCC) published the Proposed 2019 State Medical Facilities Plan (SMFP), which includes proposed need determinations of interest to a number of different types of providers. Since then, the SHCC's Acute Care Services, Long-Term and Behavioral Health, and Technology and Equipment Committees have met and recommended some changes to those need determinations, based upon petitions filed in late July to amend proposed need determinations, comments filed by interested parties, and updated data collected by agency staff. The current recommended need determinations are listed below.

No certificate of need application due dates or beginning review dates have been determined yet. Those decisions will be made after the SHCC has made its final need recommendations. The SHCC will meet on October 3, 2018 to make those final recommendations for the 2019 SMFP, which will be presented to Governor Cooper for approval. The Governor's approval typically is issued in late December, effective January 1, 2019.

Acute Care Bed Need Determination

Service Area	Acute Care Bed Need Determination
Durham/Caswell	34
Gaston	33
Mecklenburg	76

Operating Room Need Determination

Service Area	Operating Room Need Determination
Mecklenburg	6
New Hanover	6
Orange	3
Wake	2

Linear Accelerator Need Determination

Service Area	Linear Accelerator Need Determination
18 (Bladen/Cumberland/Robeson/Sampson)*	1

*Need determination limited to Robeson County.

Fixed Dedicated PET Scanner Need Determination

Service Area	Fixed Dedicated PET Scanner Need Determination
Wake	1

Fixed MRI Scanner Need Determination

Service Area	Fixed MRI Scanner Need Determination
Davie*	1
Forsyth	1
Mecklenburg	1
Wake	1

*This need determination will be removed if Davie Medical Center's pending CON application for one MRI pursuant to SMFP Policy TE-3 is approved.

Fixed Cardiac Catheterization Equipment Need Determination

Service Area	Fixed Cardiac Catheterization Equipment Need Determination
Buncombe/Graham/Madison/Yancey	1

Nursing Care Bed Need Determination

County	HSA	Nursing Care Bed Need Determination
Davidson	II	15

Adult Care Home Bed Need Determination

County	HSA	Adult Care Home Bed Need Determination
Hyde	VI	30
Macon	I	70
Mitchell	I	20
Pamlico	VI	50
Polk	I	50
Warren	IV	70

Hospice Inpatient Bed Need Determination

County	HSA	Hospice Inpatient Bed Need Determination
Cumberland	V	9

Child/Adolescent Psychiatric Bed Need Determination

Local Management Entity - Managed Care Organization (LME-MCO) and Counties	HSA	Child/Adolescent Psychiatric Bed Need Determination
Alliance Behavioral Healthcare: Cumberland, Durham, Johnston, Wake	IV, V	1
Eastpointe: Bladen, Columbus, Duplin, Edgecombe, Greene, Lenior, Robeson, Sampson, Scotland, Wayne, Wilson	V, VI	22
Sandhills Center: Anson, Guilford, Harnett, Hoke, Lee, Montgomery, Moore, Randolph, Richmond	II, IV, V	9
Vaya Health: Alexander, Alleghany, Ashe, Avery, Buncombe, Caldwell, Cherokee, Clay, Graham, Haywood, Henderson, Jackson, Macon, Madison, McDowell, Mitchell, Polk, Rutherford, Swain, Transylvania, Watauga, Wilkes, Yancey	I	17

Child/Adolescent Chemical Dependency (Substance Abuse) Treatment Bed Need Determination

Mental Health Planning Region	HSA	Child/Adolescent Chemical Dependency Treatment Bed Need Determination
Central Region	II, III, IV, V	17

Adult Chemical Dependency (Substance Abuse) Treatment Bed Need Determination

Mental Health Planning Region	HSA	Adult Chemical Dependency Treatment Bed Need Determination
Central Region	II, III, IV, V	32

Todd Hemphill focuses his practice on health care law with an emphasis on Certificate of Need law. He can be reached at themphill@poynerspruill.com or at 919.783.2958.

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This is significant because, in North Carolina, employees suing their employers under Title VII must first exhaust their administrative remedies with the Equal Employment Opportunity Commission by filing charges of discrimination within 180 days of their employers' last alleged acts of prohibited conduct. In contrast, Title IX allows employees three years to file suit in North Carolina, and contains no such administrative exhaustion requirement. This makes it that much easier for a medical resident to directly sue his/her hospital-employer for sexual harassment, discrimination, and/or retaliation.

Title IX Requirements. Given that Title IX could apply to medical residency programs in this state, private hospitals operating such programs might want to consult with counsel to determine if they should come into compliance with Title IX's numerous regulations. The Department of Education has published helpful guidance to schools outlining several of Title IX's procedural requirements. Among the requirements, Title IX mandates adoption and publication of grievance procedures that provide prompt and equitable resolution of complaints alleging violations of Title IX. The complainant should be afforded the right to adequate, reliable, and impartial investigation of complaints.

Title IX also requires the designation of one or more employees to coordinate efforts to comply with and carry out the employer's Title IX responsibilities. The designated employee(s) is responsible for overseeing the investigation of complaints alleging noncompliance with Title IX. All employees must be notified of the name, office address, and telephone number of the employee(s) designated to coordinate the Title IX compliance efforts. Additionally, Title IX requires that covered entities have and distribute policies against sex discrimination, and implement specific and continuing steps to notify employees that they do not discriminate on the basis of sex. A prominent statement of that non-discrimination policy must generally be published in each announcement or bulletin distributed to employees.

In summary, should Title IX apply to medical residency programs in North Carolina, compliance with the law's numerous procedural requirements could help ensure that a hospital-employer is in an optimal position to defend against potential claims of sexual harassment, discrimination, and retaliation brought by medical residents.

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RECENT DECISION HIGHLIGHTS POTENTIAL PERSONAL LIABILITY . . .

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action taken as a director if he performed his duties in compliance with the statute cited above. On the other hand, the corporation *may not* hold harmless or indemnify a director unless the board of directors determines that the director (1) conducted himself in good faith; (2) reasonably believed that his conduct in his official capacity was in the best interests of the corporation; and (3) in a criminal proceeding, had no reasonable cause to believe his conduct was unlawful.

Personal Director Liability Under N.C. Law. Although the North Carolina courts have recognized the "business judgment rule," *Hammonds v. Lumbee River Elec. Mbrshp. Corp.*, 178 N.C. App. 1, 631 S.E.2d 1 (2006), *review denied*, 360 N.C. 576, 635 S.E.2d 598 (2006), this rule has its limits. While a nonprofit corporation's articles, per the Act, may ostensibly protect a director from personal liability for monetary damages, the director may still be personally liable:

- if the director knew at the time that the act or omission was clearly in conflict with the best interests of the corporation;
- the director derived an improper personal financial benefit from the transaction; or
- if the director consented to an improper loan, guaranty or other security, or consented to a distribution made in violation of the Act or the corporation's articles of incorporation.

While Michigan had an unusually strong exculpatory statute for volunteer directors, the N.C. provision is narrower than the Michigan statute. Unlike in Michigan, N.C. law permits liability against a director who is aware that an action is not in the best interests of the corporation, even if the director has neither received direct financial benefit nor intentionally inflicted harm on the corporation.

The lessons from the *CMH Liquidating Trust* case are not limited to situations involving bankruptcy. The court's decision shows that hospital directors must recognize their duties, act in good faith and in the hospital's best interests, and avoid any potential conflict of interest. Volunteer directors in North Carolina with actual knowledge of a problem who fail to take action to address such issues are well advised not to rely on the business judgment rule or limited statutory immunity.

WILSON HAYMAN'S practice focuses on health care law, civil law, and administrative law and compliance with the Stark Law, Anti-Kickback statute, and other federal and state laws. He may be reached at whayman@poynerspruill.com or 919.783.1140.

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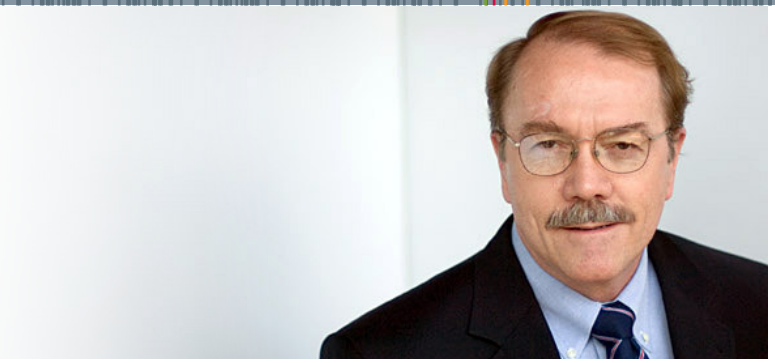

SECURING WIRELESS INFUSION PUMPS IN HEALTHCARE

by Bill Shenton

The National Cybersecurity Center of Excellence (NCCoE) announced in August that it has finalized the draft guidance, first issued in May of last year, on securing wireless infusion pumps. Infusion pumps are often tasked with supplying a steady inflow of life-saving or life-sustaining medications to hospital patients, and their exposure to the internet comes with risks of malicious manipulation, risks of patient harm, data breaches, and risks to an entire organization's computer system.

The risks of wireless medical devices have received dramatic attention, including in the episode in the *Homeland* series where a hacked cardiac pacemaker was manipulated to assassinate the Vice President. In September of 2017, the FDA issued a recall for almost a half million pacemakers, and in the same month there was news about infusion pumps' vulnerability. The FDA has been issuing guidance about the risks associated with infusion pumps and has a webpage dedicated to this issue.

The new NCCoE guidance is geared for the clinical and administrative leadership of hospitals, as well as the IT staff who run their computer networks. The IT professionals will find reams of detailed information about the features that can be employed to secure infusion pumps; and the guidance stresses that the architecture for these solutions uses commercially available hardware and software, and was developed with input from the vendors. Security professionals will want to study the entire 375-page report, but for a good visual representation of the suggested system architecture, consult the second page of NCCoE's Summary which is linked on the webpage where NCCoE's guidance is available.

The key takeaway of the guidance for the clinical and administrative staff is understanding the common vulnerabilities of these devices, which are distilled in Appendix B on pages 76-77:

- The use of removable media as part of the standard deployment of these devices can result in inappropriate disclosures of PHI, and also poses the risk of introduction of malicious software which can compromise the functioning of an individual device, but can also infect the entire system in which it operates.
- Infusion pumps will store important patient information, but may lack the ability to encrypt it, making it even more critical to avoid use of factory set login settings.
- With deployment of infusion pumps throughout a hospital, it is important to establish role-based access to limit access to particular functions to persons with appropriate privileges.
- Since infusion pumps often are deployed for years, there must be a program to assess, update, and patch them on an ongoing basis.

Appendix C in the Report contains a concise 2-page set of Recommendations and Best Practices, starting with the need to create and maintain a thorough inventory of medical devices throughout the organization, and implementing a variety of measures for all the devices, including:

- Managing the acquisition of new devices to include review of cybersecurity capabilities of new pumps and their deployment without default passwords and other default settings that would expose them to malicious attacks;
- Implementing media access controls and filters to limit access to medical devices by unauthorized actors who have infiltrated the organization's network; and
- Ensuring their physical security by removing them to a lockable space with limited access when they are not in use.

Finally, while emphasizing that the threat landscape is constantly evolving, the guidance also spotlights the repository of vulnerability management data that is maintained and updated at the National Vulnerability Database for information security professionals to access and use.

NCCoE is inviting comments on the guidance; to provide comments or to learn more, including how to arrange a demonstration of this example implementation, contact the NCCoE at: hit_nccoe@nist.gov.

For more information and additional resources regarding this article, please visit this publication on our website.

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