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SCRIPTS

Legal updates for the health care community from Poyner Spruill LLP

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Health Care Decisions — *Who Decides?*

By Julie Hampton

Like most states, North Carolina recognizes a person's fundamental right to make his or her own health care decisions. Sometimes, however, it is not possible for a patient to make or communicate a health care decision. A patient may be unconscious, comatose, or otherwise incapable of making or communicating a health care decision. In these situations, North Carolina law has clarified who can consent to medical treatment for those patients who cannot make or communicate their own decisions.

N.C.G.S. § 90-21.13 provides the framework for a provider to determine who has the authority to make the health care decisions for the incapable patient. I have outlined below in order of priority the following persons who can consent to or withhold consent for medical treatment for a person who is not able to make or communicate his or her own health care decisions.

1. Someone holding a valid health care power of attorney (health care agent) to the extent authorized by the power of attorney, unless the court has appointed a guardian for the patient and also suspended authority of the health care agent.
2. If there is no health care agent as defined in (1), a court-appointed guardian or general guardian.
3. If there is no guardian as provided in (2), an attorney-in-fact who is granted power over health care decisions by a valid power of attorney.
4. If there is no attorney-in-fact as provided in (3), the spouse of the patient.
5. If there is no spouse as provided in (4), a majority of the patient's reasonably available parents and adult children.
6. If there are no reasonably available parents and adult children as provided in (5), then a majority of the patient's reasonably available adult siblings.
7. If there are no reasonably available adult siblings as provided in (6), then an individual who has an established relationship with the patient, who is acting in good faith on behalf of the patient and who can reliably convey the patient's wishes.
8. If none of the above are available, the patient's attending physician may provide medical treatment to the patient without patient's consent if another physician confirms patient's condition and necessity for medical treatment provided. However, this confirmation by a second physician is not required if delay caused by obtaining confirmation would endanger the patient's life or seriously worsen the patient's condition.

The above-referenced listing is provided for use as a quick assessment tool. These provisions do not supersede the procedures for natural death in the absence of a declaration. Those procedures are only applicable where an "attending physician determines, to a high degree of medical certainty, that a person lacks capacity to make or communicate health care decisions and the person will never regain that capacity," and the physician determines that person has an "incurable or irreversible condition that will result . . . death within a relatively short period . . . or is unconscious and, to a high degree of medical certainty, will never regain consciousness," and there is confirmation of the condition in writing by a physician other than the attending one, and a "vital bodily function could be restored or is being sustained by life-prolonging measures." In cases where those conditions are met and no instrument declaring intent for a natural death has been executed, life-prolonging measures may be withheld or discontinued under supervision of the attending physician with concurrence of the same persons in the same order as provided above for health care decisions under N.C.G.S. §90-21.13.

Julie Hampton is a commercial litigator, pursuing and defending contract-based claims for the construction, real estate, health care, and financial services industries. She may be reached at 919.783.2819 or jhampton@poynerspruill.com.

Medical Software Licensing — *Tips from the Trenches*

By Eric Stevens

Medical offices are adopting complex software products such as electronic health record (EHR) systems and practice management systems in increasing numbers. While the ultimate hope is to improve patient care and practice efficiencies (and qualify for governmental incentives), short-term results for many practices do not meet expectations. A 2013 survey by the American College of Physicians, for instance, found that user satisfaction with EHR systems fell by 12 percentage points between 2010 and 2012. In some cases medical practices have discontinued use of unsatisfactory software systems and even initiated lawsuits against vendors, alleging that the software was defective or the vendors misled them about its capabilities.

Any medical practice that has terminated an unsatisfactory software license and then fought a litigation battle with the vendor will tell you that the experience was quite debilitating (regardless of the outcome of the lawsuit). The disappointment of a failed effort to adopt new software would be bad enough even if not compounded by the expense, distraction, and uncertainty of litigation and the need to find replacement software. Fortunately, though all major software projects have their share of hiccups, few result in failure and litigation. Our experience as litigation counsel for software customers against their vendors has shown that failed software implementations tend to result from a common pattern of errors in the software selection, contract negotiation, and software installation phases of a project. Avoid these common errors and your practice will be much more likely to find satisfaction in your new software package.

Software Selection Mistakes

Medical practices and their IT staff are typically savvy enough to pursue a deliberate software selection process that includes a detailed request for proposals, careful scoring of request for proposal (RFP) responses, hands-on demonstrations, and careful consultation of references. Despite this, software project failures often occur simply because the customer selects the wrong software. Here are a few common software selection errors that customers make.

1. **Selecting Untested Software.** Given a choice between a cutting-edge product with enticing new features and a mature product with more basic features offered by an established vendor, it can be tempting to choose the newer product with more features. The companies that end up in litigation, however, tend to be the ones that select the untested product. Even mature software can be risky if you are counting on new features that have not been widely tested and used. At a minimum, if you select unproven software or software with untested features (or designed to satisfy new governmental standards such as "meaningful use" of EHR systems), seek robust warranties and plan to be patient while the vendor addresses the inevitable bugs and issues that accompany untested software and software features.

2. **Selecting Software That Requires Building New Interfaces.** New software systems often must seamlessly share data with existing information systems. For instance, a new EHR system should be able to exchange patient information with your existing practice management system. Despite industry and governmental standardization efforts, however, health care software products are not as compatible with one another as they ought to be, and many failed software projects were bedeviled by difficulties in building interfaces. The safest course is to seek confirmation that the systems you want to connect are already successfully speaking to one another, using the same interface your practice will employ, at several other medical practices similar to yours. If this is not possible and it will be necessary to build a new interface, be sure to include ample time in the project schedule to complete the task and be sure that the vendors of all affected software will cooperate as necessary.

3. **Excessive Reliance on Sales Promises.** Software litigation often turns on the customer's claim that the vendor—whose sales representatives operate on commission—made misleading representations about the capabilities or features of the software. These claims are usually complicated, at a minimum, by disclaimer language in the license agreement. Generally, your practice should not expect software to satisfy any metric or include any feature unless that capability or feature is identified as fully operational in the written contract (e.g., through an RFP response incorporated into the agreement). If the vendor's sales representative promises to add a new feature or capability to your software or claims that the software can be configured to satisfy your need, this claim should be memorialized in the agreement, which

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should also specify: (a) when the feature or function or configuration will be ready; (b) how much it will cost, if anything; (c) that the new feature will not adversely affect the other operations of the software; and (d) that the vendor will provide full support for the new feature consistent with its support for the entire software product.

Contract Negotiation Errors

After selecting the wrong software, customers often fail to protect their interests during contract negotiations. Contract negotiations should be handled by qualified legal counsel, and this article does not provide a comprehensive checklist of necessary license provisions. Here, though, are three common contract drafting errors that software customers make.

1. **Failure to Demand Adequate Warranties.** When you are spending substantial time and money on new software, it is inexcusable not to insist that the vendor fully stand behind its product. Warranty language will depend on many factors but at a minimum should provide: (a) that, for a reasonable period of time following acceptance of the software, all material features of the software (identified in detail in writing), including any custom features and interfaces, will operate properly without defect; (b) that hardware provided by the vendor will operate without defect for a reasonable time; and (c) that all services provided by the vendor will be provided in a timely, skillful, professional, and workmanlike manner by qualified and experienced personnel in accordance with industry standards. If you expect the software to satisfy particular requirements—for instance EHR "meaningful use" requirements or HIPAA or HITECH privacy and security standards—the written warranty should adequately cover these and provide satisfactory remedies in the event of a breach. Of course the contract also must provide adequate levels of support after implementation.

2. **Failure to Secure Adequate Leverage.** A good contract should build in multiple leverage points to keep the vendor – which may be apt to lose focus after locking you into the agreement -- on track. The contract price should be payable in installments tied to specific project milestones rather than paid in advance. The final payment should not be due until after you accept the software. Acceptance should not occur until the software is installed and operating in your practice and you have fully tested all of its features and found them satisfactory. There should be a formal "notice and cure" procedure to address defects or bugs that arise during the installation period. A written project schedule should specify realistic deadlines for completion of major milestones and the contract should provide that "time is of the essence," thus giving those deadlines teeth. Finally, the contract should provide that the vendor cannot hold you in breach for withholding any payment if you dispute whether payment is due in good faith, give notice of the basis for the dispute, and place disputed payments in escrow until the dispute can be resolved.

3. **Failure to Demand Qualified Support Personnel.** Software implementation failures can often be attributed to incompetent or inexperienced vendor support personnel who fail to respond adequately to issues that arise in the course of a project. Customers should demand contractual assurance that the project manager assigned by the vendor is qualified and has substantial experience implementing your software and should ask to speak to a representative of another practice who worked with the same person. Customers should also push for the right, at least once during the implementation phase of the project, to require the vendor to replace an unsatisfactory project manager.

Software Implementation Errors

A smart selection process and a good contract do not by themselves guarantee a successful software project. There are plenty of errors to be made after the contract is signed. Here are three to avoid.

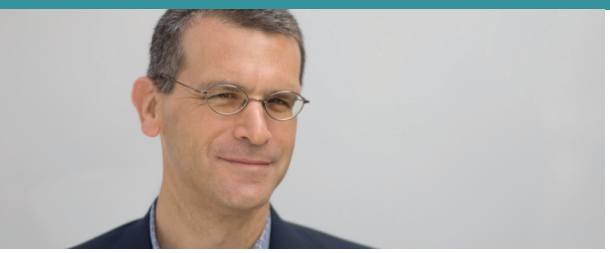
1. **Failure to Fully Commit.** Busy medical practices sometimes enter into software projects without planning properly and devoting adequate resources to the task. You must assign appropriate personnel to the project and ensure they have the time, tools, and institutional support to complete the work. Everyone in the organization must participate in training and make the effort needed to properly use the software once installed.

2. **Failure to Communicate Clearly with the Vendor.** Issues inevitably arise during any software implementation, but the vendor can only address concerns you clearly and promptly articulate. Problems allowed to fester are much more difficult to solve. Comply with the vendor's reporting procedures and be mindful of any contractual notification requirements. Consider suggestions and work-arounds offered by the vendor with an open mind, but be firm in expecting the vendor to deliver what you bargained for in a timely manner. Keep clear records of all vendor communications. Document all agreements and understandings you reach with the vendor during implementation.

3. **Failure to Use Your Leverage.** A well-negotiated contract is only useful if you take advantage of the tools it provides. If the software is defective or the vendor's performance is inadequate, use the leverage at your disposal. Withhold interim payments until you are satisfied that the vendor has reached the associated milepost. Do not accept the software until it is fully operational and all features have been tested. Use your right to place disputed payments in escrow. Demand that unsatisfactory or inexperienced support personnel be replaced.

So long as you are careful to avoid these common errors that can lead to vendor disputes, the odds are great that your practice will successfully adopt and reap the benefits of your new software.

Eric Stevens focuses his practice on intellectual property law and litigation. He may be reached at estevens@poynerspruill.com or 919.783.1017.



An Ounce of Prevention — *The Importance of Periodic Corporate Audits*

By Dave Krosner

Most, if not all, health care providers operate their businesses in an entity form, such as a corporation or limited liability company (LLC). Many use multiple entities—for example, one entity to own the real estate (or a separate entity to own each parcel of real estate) and another to operate the business.

Although the type of entity (or entities) used in your business was likely selected based on an evaluation of the benefits and drawbacks of each type of entity (including tax considerations and management structure), one of the principal benefits of both a corporation and LLC is limited liability, which is often referred to as the "corporate veil" or "corporate shield." The corporate veil refers to the concept that the owners of the corporation or LLC are generally not liable for the debts and obligations of the entity. Rather, the corporate veil protects the owners from that personal liability and places responsibility for the entity's debts and obligations on the entity.

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"The corporate veil refers to the concept that the owners of the corporation or LLC are generally not liable for the debts and obligations of the entity."

As we all know, for every rule, there are exceptions, and that holds true with respect to the corporate shield. Some of these exceptions are created by statutes and others by case law. For example, under federal statutes, employees who are responsible for the entity's payroll or financial affairs may be personally liable (and also subject to penalties) for willfully failing to collect and remit required federal withholding or employment taxes. Similarly, under certain federal environmental laws, corporate officers who have authority and control over the disposal of hazardous wastes can be held personally liable for the corporation's failure to comply with certain environmental laws.

In the category of case law-type exceptions, generally an individual will always be liable for his own wrongdoing. For example, if I get frustrated at work and punch my partner in the nose, the corporate shield will not protect me from liability to my partner! We all understand (and can't legitimately complain about) those types of exceptions to the corporate shield. But there is also a broader set of case law that creates additional exceptions that allow plaintiffs to "pierce the corporate veil." Under this concept, a judge may decide that the facts of a particular case warrant piercing the corporate veil and, thereby, holding the owners of the entity personally liable for the matter being litigated. Generally, the courts examine a laundry list of factors, including, most important, whether the facts suggest that a refusal to pierce the corporate veil would result in fraud or similar injustice.

Generally, to succeed in a veil piercing case, the plaintiffs would have to prove, among other items, that the owners of the entity so dominated its finances, policy, and business that the entity had no separate mind, will, or existence of its own. In determining whether that level of control exists, a court looks to several factors (none of which are typically decisive in and of themselves). These factors include (i) inadequate capitalization of the entity, (ii) noncompliance with corporate formalities, (iii) excessive fragmentation of a single enterprise into multiple entities, (iv) absence of company records, and (v) siphoning of funds from the company by the dominant owner.

Although the case law rules for veil piercing vary somewhat from state to state, the good news is that courts are typically very reluctant to pierce the corporate veil. The perhaps better news is that there are steps you can take to make it less likely that the veil of your entity will be pierced. So what can you do to lessen the risk of a successful veil-piercing claim? For one, be sure your entity complies with appropriate corporate formalities and maintains appropriate corporate records. For example, if your entity is a corporation, each year the corporation should hold a shareholders' meeting to elect its Board of Directors and the directors should appoint the officers. All major corporate actions should be approved by the Board of Directors, and records of those approvals should be maintained. If money is distributed to the owners or there are multiple entities and money flows between the entities, all of this should be approved in writing by the directors and properly documented. Generally, these types of records are kept in the entity's minute book. If the last entry in your minute book dates from 1982, your entity is not keeping proper records!

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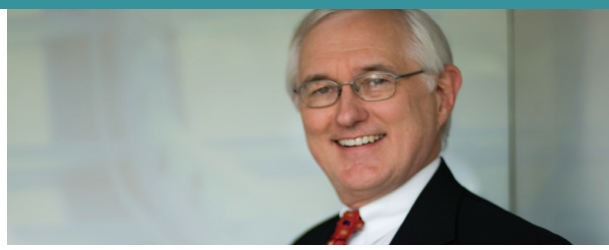
The Affordable Care Act — How Did Two Courts Make Opposite Decisions on Tax Subsidies

By Steve Shaber



How did two courts reach opposite decisions about tax subsidies for people who buy insurance through the federal exchanges created by the Affordable Care Act (ACA)? In *Halbig v. Burwell*, the U.S. Court of Appeals for the District of Columbia ruled, 2 to 1, that the subsidies are only available to people who enroll in exchanges set up by the states. In *King v. Burwell,* the U.S. Court of Appeals for the Fourth Circuit (which includes North Carolina) held, 3 to 0, that the subsidies are available to people who enroll in the federal exchange as well as those who enroll in the state exchanges.

Is this all just partisan hooey? Or legal legerdemain? Or too complicated to worry about? Actually, the cases are pretty straightforward. They boil down to this.

1. Legislators sometimes write ambiguous laws (the way toymakers write assembly instructions).
2. A statute is ambiguous when one part of the law contradicts another part.
3. When a statute is ambiguous, courts are supposed to save it, if they can, rather than discard what the legislators tried to do.
4. Sometimes a law is too muddled to save.

How do these points apply to the ACA? The purpose of the statute is to increase the number of insured people in each state. These people need a place to buy insurance, and some states are willing to set up exchanges where they can do this. However, other states do not want to set up exchanges themselves, so in those states people can go to a federal exchange. Either way, if lots of people sign up, the insurance pool gets bigger in each state, so premiums go down.

Of course, some people cannot afford to buy insurance, so if those people are going to be in the pool and push down the cost, they need to have help paying their premiums. One way to help them is to give them subsidies in the form of tax credits.

Unfortunately, the ACA has a clause which is clear by itself but is also completely inconsistent with the purpose of the law. That clause says the tax subsidies are available to people who buy insurance through exchanges "established by the State." By themselves, these four words preclude any subsidy for anyone who buys insurance through the federal exchange, in which case fewer people enroll and premiums stay higher.

So, what is the court to do? Give precedence to the four words, and undermine the statute? Or give meaning to the statute as a whole, and bend these four words so that if a state elects to use the federal exchange it is in effect establishing the federal exchange within it?

If you wonder what you would do, consider this (frivolous) example. Suppose you want to leave the Wilmington beaches and drive to California, and suppose you've been given instructions that say, "Leaving Wilmington, turn left onto I-40 and drive west all the way to Barstow." Now, suppose that from where you are, the turn onto I-40 is a right, not a left. Will you turn right, drive west, and reach California? Will you turn left, drive 10 miles, and reach the Atlantic? Or will you sit and go nowhere?

The DC Circuit's majority decided to sit still. To it, the words "established by the State" are clear and unavoidable even though they undercut the rest of the ACA. The Fourth Circuit, along with the dissenting judge on the DC Circuit, decided to "turn right" and go where Congress intended.

Steve Shaber has spent his entire career in health law—first with the North Carolina Attorney General's Office and, since 1985, in private practice. He may be reached at sshaber@poynerspruill.com or 919.783.2906.

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As a service to our clients, we often conduct legal reviews of a client's corporate or LLC records, including, as applicable, minute books, shareholders' or operating agreements, articles of incorporation or articles of organization, bylaws, annual reports, stock transfer ledgers, foreign qualifications, good standing certificates, tax clearance certificates, etc., to ensure the records are up to date, reflect the current operations of the company, comply with current law, and generally reflect compliance with the governing documents and formalities applicable to the company. To the extent we find deficiencies, we propose a course of action and help our clients implement corrections. This is an easy and inexpensive way for you to eliminate one of the factors associated with piercing the corporate veil and help protect owners from personal liability.

Dave Krosner has extensive experience in all aspects of business transactional work, including mergers and acquisitions and securities compliance. He may be reached at dkrosner@poynerspruill.com or 919.783.2844.

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Health Care Law Firm Bode Hemphill Joins Poyner Spruill

On June 1, 2014, the boutique health care law firm Bode Hemphill, LLP, joined Poyner Spruill, bringing our health law team to 14 members.

Ken Burgess, health law practice group leader, said, "We are extremely pleased to have Todd Hemphill, Matt Fisher, and David Broyles, as well as their assistant, Janet Plummer, join us. Todd and his team have ably served their clients and are recognized as leaders in their field. Merging their significant skills and talents with our health law team will enable us together to expand the array of legal services available to our clients."

S. Todd Hemphill joined our team as a Partner. He has been practicing law in Raleigh since 1982. Since joining Bode Hemphill in 1986, his practice has been focused on health law, including health care strategic planning issues, assisting clients in developing health care development strategies under the Certificate of Need law, negotiating health care transactions, and litigating Certificate of Need awards and denials. Todd is a member of the N.C. Bar Association's Health Law Council and a board member of PineCone, the Piedmont Council of Traditional Music. Hemphill said, "I have worked with the health law attorneys at Poyner Spruill for many years and am excited that we will be joining such an accomplished group of attorneys. The time was also right to be able to broaden our services to existing clients, and Poyner Spruill is the perfect fit." He may be reached at 919.783.2958 or themphill@poynerspruill.com.

Matthew A. Fisher also joined the team as a Partner. For the past eight years, he has been with Bode Hemphill, litigating Certificate of Need cases and other health care matters, including appeals challenging certification and licensure survey decisions, and penalties and issues pertaining to DMA provider payment denial. Prior to joining Bode Hemphill, he defended and litigated commercial, business, medical malpractice, insurance coverage, and general liability tort cases at a large North Carolina insurance defense firm. Matt is a member of the Board of Directors of the N.C. Society of Health Care Attorneys. He may be reached at 919.783.2924 or mfisher@poynerspruill.com.

David R. Broyles joined us as an Associate. His practice centers on advising health care clients on state and federal regulatory compliance, operational and strategic planning issues, and a multitude of revenue issues, including third-party insurance payers, commercial managed care payments, Medicare, and Medicaid. David also represents health care providers in litigation related to Certificate of Need awards and denials, Medicaid reimbursement, and health care facility licensure and certification. He is secretary/treasurer and a member of the Board of Directors of the N.C. Society of Health Care Attorneys and a board member of the NC Museum of History Young Associates. He may be reached at 919.783.2923 or dbroyles@poynerspruill.com.

Now that Todd, Matt, David, and Janet (legal assistant to Todd, Matt and David) have settled into their new digs in downtown Raleigh, we will be visiting as many clients and friends as time will allow in order to introduce them to you personally. They will also be with us at most of the health care-related trade shows this year—stop by our exhibit and say hello!

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