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Healthcare Law

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HEALTHCARE LAW

Larry A. "Max" Maxwell*

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THIS is the first year the Texas Survey has devoted a chapter solely to health care law. The introduction of this topic to the Survey occurs during a period of intense interest both locally and nationally as “health care reform” has been the subject of considerable debate in Congress and the state legislature. The magnitude of this intensity on the federal level is general public knowledge given the media exposure to the many hearings and discussions by President Clinton’s Task Force. That Task Force ultimately produced the 1342-page Health Security Act that was hotly debated but not passed by either House of Congress.

At the state level, the same degree of intensity occurred during the 73rd Texas legislative session where twenty health care agencies were

subject to sunset review¹ and approximately six hundred bills affecting hospitals were filed.² Of those filed, some 150 were enacted, most becoming effective on September 1, 1993.³

Although the purpose of the Survey is to identify developments that have arisen in Texas, some of the following discussion will include matters that emanate from federal law, regulation, and Court of Appeals for the Fifth Circuit cases that relate to Texas. For purposes of this initial article, health care law issues will cover the period between August 30, 1993 and December 31, 1994. This review period has been extended back to include 1993 legislation and forward a few months to include significant recent developments.

The scope of "health care law" is not a precise body of law but is best defined by the issues affecting the various participants in the field. In a general sense, participants do one of the following: provide care, receive care, pay for care, or regulate payors or providers of care. Even though tort claims are related to patient care, this Article will not deal with issues involving medical malpractice or products liability except to the extent that a related issue affects the operation or mode of business of the particular participant.

Organizationally, this Article will discuss matters on a subject issue basis since one or more participants may be involved in any particular subject issue. Where a subject area has substantial recent legislative change, the subject area will be separated into case law and legislative/regulatory change.

I. DEVELOPMENTS INVOLVING AIDS

A. RIGHTS RELATED TO HIV-INFECTED HEALTHCARE WORKERS

The right to reassign a healthcare worker with a communicable disease was upheld in *Bradley v. University of Texas M.D. Anderson Cancer Center*.⁴ The HIV-infected worker who served as a surgical assistant involved in invasive procedures was reassigned to a position that did not involve patient care. The worker objected to the reassignment and filed suit, claiming discrimination.

The Fifth Circuit, in hearing the worker's appeal, applied the Rehabilitation Act of 1973⁵ to determine whether he was "otherwise qualified" to perform the functions of a surgical assistant in spite of his HIV infection.

1. TEX. GOV'T CODE ANN. §§ 325.001-325.024 (Vernon 1988 & Supp. 1995). Sunset review is a process required by the legislature to review the necessity of the particular agency and whether its purposes and methodologies should be modified or whether the agency should be consolidated with another or abolished.

2. CHARLES BAILEY ET AL., *NEW HEALTH CARE LAWS: A REPORT ON THE 73RD TEXAS LEGISLATURE* (Ann Ward ed., Texas Hosp. Assoc. 1993).

3. Hugh M. Barton, *Changes in the Law Will Affect Physicians*, TEX. MED., Dec. 1993, at 43.

4. No. Civ. A. H-92-189, 1993 WL 413143 (S.D. Tex.), *aff'd*, 3 F.3d 922 (5th Cir. 1993), *cert. denied*, 114 S. Ct 1071 (1994).

5. 29 U.S.C. §§ 701-797b (1988 & Supp. V 1993) (Rehabilitation Act).

In arriving at its support for the reassignment, the court made the following observations and findings:

1. Although infected blood could transmit the disease from the worker to the patient, it was too speculative to determine the probability of such a transmission;
2. even though the probability was uncertain, the risk was not so low considering the seriousness of a resultant infection; and
3. since the risk of even a low probability transmission could be disastrous, the worker was not "otherwise qualified" as a surgical assistant.
4. There was no duty upon the hospital to find the worker another position because it could not make "reasonable accommodations" to reduce the risks associated with the "essential functions" required as a surgical assistant.⁶

B. REFUSAL TO TREAT AIDS PATIENTS

As a general rule, health care providers, including physicians and dentists, are free to decide which patients they wish to treat. This free choice is subject to limitations involving constitutionally prohibited discriminations if the provider participates in state or federal payment programs such as Medicare or Medicaid. In a recent case, *United States v. Jack Castle, D.D.S.*,⁷ the court held that patients who are HIV-infected are subject to the protections afforded by the Americans with Disabilities Act. This case involved the denial of treatment to a patient who had answered a questionnaire that he was HIV-positive. The case was settled by agreement with the Department of Justice; the terms involved payment of \$80,000 compensatory damages and \$20,000 in civil penalties, although there was no admission of violation of the ADA since Dr. Castle asserted that the staff that took the actions were not authorized by policy or procedure to do so.

II. ANTITRUST

A. LEGISLATION

Amendments to the Health and Safety Code provide for the development of cooperative agreements among hospitals that allocate health care equipment, facilities, personnel, or services.⁸ This legislation permits discussion and negotiation with respect to the cooperative agreement, but does not authorize the merger of facilities or discussion of price-fixing or predatory pricing.

A cooperative agreement requires that the parties to the agreement apply to the Texas Department of Health (TDH if seeking to obtain a

6. 3 F.3d at 924-25.

7. No. H-93-31450 (S.D. Tex. Sept. 23, 1994) (case settled).

8. TEX. HEALTH & SAFETY CODE ANN. §§ 313.001-.008 (Vernon Supp. 1995) ("Cooperative Agreements Among Hospitals").

certificate of public advantage (certificate).⁹ In the application to TDH for the certificate, TDH will evaluate the potential advantages and disadvantages of the proposed agreement to determine whether any of the following would occur:

A. Advantages¹⁰

1. Enhance quality of care,
2. preserve availability of services to a specific area,
3. increase cost efficiency of services,
4. improve utilization of hospital resources and equipment, and
5. avoid duplication of resources.

B. Disadvantages¹¹

1. Difficulty caused by a cooperative agreement which would interfere with or reduce the likelihood of health maintenance organizations, preferred provider organizations, or other payors of health services being able to contract with providers of health care,
2. any reduction in competition among providers of services or goods that compete with those involved in the cooperative agreement,
3. negative effects on the quality, availability, or price of services to patients, and
4. restrictions on the availability of arrangements that are competitive to the cooperative agreement.

The process of review and determination by TDH may involve public hearings but must involve consultation with the Attorney General to assess anticompetitive effects. At any time before, during, or after the granting of a certificate, either TDH or the Attorney General may seek review and cancellation of the certificate if circumstances change such that the benefits of the agreement no longer outweigh the disadvantages of the arrangement.

B. REGULATIONS

Regulations adopted by the TDH amplified on the enabling legislation related to co-operative agreements (Agreement) between hospitals.¹² The regulations clarified that only facilities licensed by TDH could submit co-operative agreements for review and approval.¹³ The application requirements were enumerated¹⁴ and also specified that the agreement was to be fully executed by all parties.¹⁵

9. *Id.* § 313.002(b).

10. *Id.* § 313.002(e)(1)-(5).

11. *Id.* § 313.002(f)(1)-(4) (Vernon Supp. 1995).

12. 25 TEX. ADMIN. CODE § 134.101 (West 1995).

13. *Id.* § 134.101(b)(1)(A).

14. *Id.* § 134.101(b)(2).

15. *Id.* § 134.101(b)(1)(C).

Application requirements that were distinctive amplifications of the enabling legislation include the following:¹⁶

1. An identification of the steps necessary for a potential competitor of the Agreement to enter into the relevant market;
2. a historical description of the business transactions of the parties to the Agreement that relate to the subject of the Agreement;
3. an explanation of the effects of the Agreement on each party including volume, price, and revenue;
4. a description of the market share of the parties to the Agreement and other providers of the same service before and as projected after implementation of the Agreement; and
5. an explanation of why efficiencies could not be achieved without implementation of the Agreement.

In addition to the preceding requirements, TDH may deny an application if it determines that "there is not clear and convincing evidence that the likely benefits resulting from the agreement outweigh any disadvantages attributable to a reduction in competition"¹⁷

III. BUSINESS DEVELOPMENTS

A. NON-COMPETITION AGREEMENTS

The 1993 legislative session modified the part of the Business and Commerce Code relating to covenants not to compete.¹⁸ The revision allows a covenant not to compete to be part of an otherwise enforceable agreement *without* the payment of additional consideration.¹⁹ If the agreement is found to contain unreasonable limitations as to time, geographic area, or scope of activity to be restrained a court may reform the agreement to appropriately protect the business interests of the person or entity benefitting from the covenant.²⁰ The revision also specifically is made applicable to agreements *for a term or at will*.²¹

B. NON-PROFIT HEALTH CORPORATIONS

The label "Non-profit health corporation" (NPHC) is an industry coined term used for a type of "state" non-profit corporation that meets certain requirements of the Medical Practice Act (MPA)²² and has been reviewed and certified by the Texas State Board of Medical Examiners (TSBME).²³ It is also frequently referred to as a "5.01(a)" corporation

16. *Id.* § 134.101(b)(2)(0)-(s).

17. *Id.* § 134.101(c).

18. TEX. BUS. & COM. CODE ANN. § 15.50 (Vernon Supp. 1995).

19. *Id.*

20. See *General Devices, Inc. v. Bacon*, 836 S.W.2d 179, 183 (Tex. App.—Dallas 1991, writ denied) (citing *Weatherford Oil Tool Co. v. Campbell*, 340 S.W.2d 950, 951 (Tex. 1960)).

21. *Id.* But see *Light v. Centel Cellular Co. of Texas*, 883 S.W.2d 642, 645 (Tex. 1994) (at-will employment agreement not sufficient consideration for covenant not to compete).

22. TEX. REV. CIV. STAT. ANN. art. 4495b § 5.01(a) (Vernon Supp. 1995).

23. *Id.* at 501(b).

because its organizational documents and structure conform to specifications in section 5.01(a) of the MPA.

Although this type of corporate structure has been authorized for many years, its utilization was minimal until recently. Much attention has been focused on this legal structure as a mechanism for the employment of physicians by a corporation which is otherwise prohibited by the MPA.²⁴ Except for this corporate form, the only other mechanism for employment of a physician is by another physician or by a professional association composed entirely of physicians.

This non-profit health corporation structure, in an indirect manner, allows a person or entity other than a physician to be involved in the employment of the physician. This is possible since the Texas Non-Profit Corporations Act²⁵ permits a state non-profit corporation to be organized either with or without "members."²⁶ The member of the typical NPHC is a corporate entity such as a hospital.

In the development of the NPHC's organizational and structural design, the member often reserves many powers including the right to appoint the board of directors or trustees (Board) of the corporation. To meet the requirements of 5.01(a) of the MPA, all of the Board directors or trustees must be physicians practicing full time and licensed by TSBME.

Because of concerns expressed by various associations that the current arrangements may allow a corporate entity to unduly influence an employed physician's exercise of independent medical judgment, the TSBME has proposed a number of regulatory changes²⁷ that would affect the organizational design that many existing NPHC's have incorporated.

The regulations are intended to minimize the possible influence that a corporate member might have on the activities of the corporation, its board of directors, or employees that involve the practice of medicine. Since one of the principal uses of a NPHC is the employment of physicians,²⁸ those regulatory changes that relate to this purpose are outlined as follows:²⁹

1. The "full-time" practice of medicine which is a requirement for an individual to serve as a member of the governing board is expanded to include those activities dealing with professional, managerial, administrative, or supervisory activities related to the practice of medicine or delivery of health care services.³⁰

24. *Id.* § 3.08(15).

25. TEX. REV. CIV. STAT. ANN. art. 1396 (Vernon 1980 & Supp. 1995) (Non-profit Corporation Act).

26. *Id.* art. 1396-2.08.

27. 19 Tex. Reg. 9826 (1994) (if adopted to be codified at 22 TEX. ADMIN. CODE § 177.1 (Texas State Board of Medical Examiners)).

28. It should also be noted that another purpose of an NPCH is its ability to enter into certain "risk-sharing" contracts without the NPCH having to be licensed as an HMO. See TEX. INS. CODE ANN. art. 20A.26 § (f)(1) (Vernon Supp. 1995).

29. 19 Tex. Reg. 9826-9828 (1994).

30. *Id.* at 9826-27 (to be codified at 22 TEX. ADMIN. CODE § 177.1(a)(4)).

2. The physicians who serve as the initial incorporators for purposes of becoming a non-profit corporation would have the right to select the initial governing board members.³¹
3. Appointment of governing board members after the initial governing board by the "corporate member" must receive approval by a majority of the physician governing board.³²
4. Activities of the corporation that involve credentialing, quality assurance, utilization review, and peer review are the exclusive domain of the physician governing board; financial matters can be limited to the discretion of the corporate member.³³
5. Any decision to terminate a physician's employment contract with the NPHC must be approved by the physician governing board and would be subject to any "due process" requirements adopted by the governing board.³⁴
6. A physician governing board member can be removed by the "corporate member" only "for cause" as stated in the NPHC bylaws; "for cause" can not involve matters relating to credentialing, quality assurance, utilization review, peer review, or the practice of medicine.³⁵
7. The "corporate member" can not unilaterally amend the NPHC bylaws and must receive a majority approval from the physician governing board.³⁶
8. Annual reporting requires submission of various types of information including financial relationships between the physician board members and the "corporate member" of the NPHC.³⁷
9. The TSBME is authorized to withhold or revoke a NPHC's certification if the NPHC does not meet the requirements of section 5.01a of the Medical Practice Act.³⁸

These proposed rules will be subject to public comment during the spring of 1995, when the TSBME expects to take final action.

C. REIMBURSEMENT

In a transaction between two corporate entities in which the acquiring entity assumed no liabilities in the purchase according to state law, the Fifth Circuit Court of Appeals in *United States v. Vernon Home Health, Inc.* held that federal regulations could impose liability on the acquiring entity.³⁹ In this transaction, the acquiring entity accepted transfer of the selling entity's Medicare provider number. In the course of a periodic audit review it was determined that the selling entity had been overpaid by the Medicare program during the operation of home health agency by the seller. Even though the liability for repayment would have been di-

31. *Id.* at 9827 (to be codified at 22 TEX. ADMIN. CODE § 177.1(b)(1)).

32. *Id.* (to be codified at 22 TEX. ADMIN. CODE § 177.1(b)(4)).

33. *Id.* (to be codified at 22 TEX. ADMIN. CODE § 177.1(b)(5)).

34. *Id.* (to be codified at 22 TEX. ADMIN. CODE § 177.1(b)(6)).

35. *Id.* (to be codified at 22 TEX. ADMIN. CODE § 177.1(b)(7)).

36. *Id.* (to be codified at 22 TEX. ADMIN. CODE § 177.1(b)(8)).

37. *Id.* (to be codified at 22 TEX. ADMIN. CODE § 177.1(c)).

38. *Id.* at 9828 (to be codified at 22 TEX. ADMIN. CODE § 177.1(i)).

39. 21 F.3d 693, 696 (5th Cir.), *cert. denied*, 115 S. Ct. 575 (1994).

rected to the seller, state law was preempted by federal Medicare regulations.⁴⁰ Thus, the acquiring entity was held to be liable for repayment.⁴¹ Had the acquiring entity not accepted an assignment of the predecessor's Medicare provider number, liability would not have been imposed on the acquiror.⁴²

D. RELEASE OF PATIENT ACCIDENT INFORMATION

Legislation passed in 1993 prohibiting the release of information on patients involved in auto accidents⁴³ was ruled unconstitutional in *Moore v. Morales*.⁴⁴ In the same decision, Judge Hittner also struck down a similar piece of new legislation⁴⁵ which limited the release of auto accident information for 180 days from the date of the accident.⁴⁶ The laws were intended to protect accident injured individuals from solicitation by lawyers and other individuals during a time of distress.⁴⁷ The lawsuit was initiated by businesses that review information maintained by public agencies responsible for accident and criminal offense monitoring.⁴⁸ The businesses claimed that their First and Fourteenth Amendment rights under the United States Constitution were violated by the legislation.⁴⁹

The court ruled that the legislation exceeded limitations on commercial speech approved by the United States Supreme Court.⁵⁰ The court also determined that the purpose of the legislation in preventing deceptive or misleading communications was not served by imposing time limits.⁵¹ The court further held that privacy rights of individuals were not protected by the new legislation since the information subject to the new state laws was available through other public means including insurance companies.⁵²

IV. CONSENT TO TREATMENT

A. ALTERNATE DECISION MAKERS FOR INCOMPETENT PATIENTS

The Consent to Medical Treatment Act was passed by the 1993 Legislature as amendments to the Texas Health and Safety Code.⁵³ Prior to this legislation there was no valid manner in which someone other than an adult patient himself could consent for medical treatment unless that

40. *Id.* at 695 (citing *United States v. Kimbell Foods, Inc.*, 440 U.S. 715 (1979)).

41. 21 F.3d at 696.

42. *Id.*

43. TEX. PENAL CODE ANN. §§ 38.12(d)(2)(A)-(C), 38.12(e) (Vernon 1994).

44. 843 F.Supp. 1124 (S.D. Tex. 1994).

45. TEX. REV. CIV. STAT. ANN. art. 6701d § 47(a), (b), (c), (f) (Vernon Supp. 1995).

46. 843 F. Supp. at 1133.

47. *Id.* at 1127.

48. *Id.* at 1125.

49. *Id.*

50. 843 F. Supp. at 1126, 1133.

51. *Id.* at 1126-27, 1133.

52. *Id.* at 1129-30, 1133.

53. TEX. HEALTH & SAFETY CODE ANN. §§ 313.002-007 (Vernon Supp. 1995) (Consent to Medical Treatment Act).

adult had appointed an agent under a Durable Power of Attorney for Health Care,⁵⁴ or other specific circumstances were applicable such as an emergency where consent is implied⁵⁵ or the patient met the requirements of the Natural Death Act.⁵⁶ In spite of this situation, many consent forms were signed by next of kin, which gave the health care providers involved in rendering care some sense of believing they were protected. Although technically, no valid consent existed by these next of kin consents, the providers were acting on the belief that the next of kin were acting in the best interests of the patient and expressing the wishes of the patient. These provisions clarify who and under what circumstances decisions can be made for patients who are not competent.

1. Circumstances when this Act does not apply:⁵⁷

- A. a court appointed guardian has been given authority to make decisions;
- B. a Durable Power of Attorney for Health Care has been executed which designates agents to make decisions;
- C. the medical treatment decisions involve the withholding or withdrawing of life support which is subject to the Natural Death Act;⁵⁸ or
- D. the medical treatment involves voluntary inpatient mental health services, electro-convulsive treatment, or the appointment of another alternate decisionmaker.⁵⁹

The Act does not affect existing law related to treatment of individuals in emergency conditions,⁶⁰ the treatment of minors,⁶¹ and consent with respect to transfer to another facility.⁶²

2. Patient Qualifications of the Act:⁶³

- A. the individual must be a patient at a nursing home or at a hospital for inpatient services;
- B. the patient is "incompetent" meaning that the individual is incapacitated, comatose, or incapable of communication; and
- C. the patient is in need of medical treatment according to reasonable medical judgment which includes preventive care.

54. TEX. CIV. PRAC. & REM. CODE ANN. §§ 135.001-.018 (Vernon Supp. 1995).

55. TEX. HEALTH & SAFETY CODE ANN. § 773.008 (Vernon 1992).

56. TEX. HEALTH & SAFETY CODE ANN. §§ 672.001-.021 (Vernon 1992 & Supp. 1995) (Natural Death Act).

57. TEX. HEALTH & SAFETY CODE ANN. § 313.003 (Vernon Supp. 1995).

58. *Id.*

59. TEX. HEALTH & SAFETY CODE ANN. § 313.004(d)(1)-(3) (Vernon 1992).

60. *Id.* § 313.003(a)(4).

61. *Id.* § 313.003(a)(3).

62. TEX. HEALTH & SAFETY CODE ANN. § 313.003(a)(5).

63. *Id.* § 313.005.

3. Alternate Decision Makers:

If the requirements of the Act are met, and no exception is applicable, the Act then lists in order of priority those individuals who may make decisions based upon the patient's wishes, if known:⁶⁴

- A. the patient's spouse;
- B. the patient's adult child who has the waiver and consent of all other qualified adult children of the patient to act as the sole decisionmaker;
- C. a majority of the patient's reasonably available adult children;
- D. the patient's parents; or
- E. the individual clearly identified to act for the patient by the patient before the patient became incapacitated, the patient's nearest living relative, or a member of the clergy.

4. Physician Requirements.⁶⁵

- A. The patient's competency and medical condition must be described in the medical record.
- B. Reasonable efforts to contact the alternate decision makers must be documented in the record.
- C. Documentation of the consent obtained from the alternate decisionmakers should be executed on appropriate consent forms.

If the foregoing requirements are met and all decisions are made in good faith, the health care providers involved in the care rendered are immune from civil or criminal liability with respect to consent issues.⁶⁶

B. AGE OF CONSENT FOR BLOOD DONATION

The age of consent for blood donation has been lowered from eighteen years to seventeen years of age.⁶⁷ A blood bank, however, may not pay a person younger than eighteen years of age for a donation of blood or blood components.

C. LIMITATION ON POWERS OF GUARDIAN

The Texas Probate Code was amended in 1993, revising substantially the provisions dealing with guardianship.⁶⁸ The provision conferring authority on the guardian to make health care decisions is broad, including medical, psychiatric, and surgical treatment other than in-patient psychiatric care.⁶⁹

64. *Id.* § 313.004(a)(1)-(5).

65. *Id.* § 313.005.

66. *Id.* § 313.007.

67. *Id.*

68. TEX. PROB. CODE ANN. § 767 (Vernon Supp. 1995).

69. *Id.* § 767(4).

D. SURROGATE DECISIONMAKERS FOR RESIDENTS OF MENTAL HEALTH FACILITIES

Amendments to the Health and Safety Code provide for a process to appoint a surrogate health care decisionmaker for residents of an intermediate care facility serving the mentally retarded.⁷⁰ An appointment can be made after an assessment of a resident indicates that the resident is not capable of making treatment decisions.⁷¹

1. *Decisionmakers*

The following priority lists those who can serve as surrogate decisionmakers: (1) an actively involved spouse, (2) an actively involved adult child who has the waiver and consent of all other actively involved children, (3) an actively involved parent or stepparent, (4) an actively involved adult sibling who has the waiver and consent of all other actively involved adult siblings, and (5) an actively involved adult relative who has the waiver and consent of all other actively involved adult relatives.⁷² When there is no surrogate available or willing to serve in this capacity, a surrogate consent committee which is subject to specific membership qualifications and limitations can be established to make treatment decisions.⁷³

2. *Circumstances When Surrogates Decide*

A surrogate may exercise decision making authority when the resident requires major medical or dental treatment that has a significant recovery period, presents a significant risk, employs a general anesthetic, or involves a significant invasion of bodily integrity requiring extraction of bodily fluids or an incision, or that produces substantial pain, discomfort, or debilitation.⁷⁴

3. *Limitations on Decisionmaking*

The surrogate may not make health care decisions involving: (1) experimental research, (2) abortion, (3) sterilization, or (4) electroconvulsive treatment.⁷⁵ The surrogate may not make decisions about management of client funds.⁷⁶

V. CONTRACT DEVELOPMENTS

An exclusive contract arrangement between a hospital and physician was challenged in a lawsuit appealed to the Texarkana Court of Ap-

70. TEX. HEALTH & SAFETY CODE ANN. §§ 597.001-.055 (Vernon Supp. 1995).

71. *Id.*

72. *Id.* § 597.041(a)(1)-(5).

73. *Id.* § 597.042.

74. *Id.* §§ 597.001(6), 597.041(a).

75. TEX. HEALTH & SAFETY CODE ANN. § 597.003(a) (Vernon Supp. 1995).

76. *Id.*

peals.⁷⁷ Dr. Gonzalez's practice was essentially eliminated at the hospital since he was not associated with the physician who obtained the exclusive contract for anesthesiology services. In the suit he claimed that contract rights were breached, business relations were tortiously damaged, and restraint of trade was involved in the exclusive arrangement.⁷⁸ While the court's opinion on the restraint of trade claim applied existing precedent from the *Jefferson Parish*⁷⁹ case,⁸⁰ the court did create new implications in the breach of contract issue⁸¹ and affirmed the hospital's course of action for those matters claimed to involve tortious interference.⁸²

A. BREACH OF CONTRACT

Dr. Gonzalez claimed that the hospital's governing bylaws which established a procedure for hearing and appeal were breached when he was effectively denied the right to practice at the hospital without such a hearing. The hospital contended that the case was controlled by *Weary v. Baylor University Hospital*⁸³ and its progeny, which held that medical staff bylaws did not create contractual rights. The Gonzalez court, however, made the distinction between medical staff bylaws and hospital governing board bylaws in holding the hospital governing board bylaws did create such rights.⁸⁴ It did note that these "contract rights" did not guarantee work for any physician nor did they limit the hospital's right to conduct business including exclusive contracting.⁸⁵

The court also considered the basis for which hearings and appeals were made available and decided that since neither professional competence nor ethical conduct were at issue, there was no reason for Dr. Gonzalez to be afforded a hearing.⁸⁶ It determined that his privileges and membership at the hospital continued in place and that his ability to obtain work which had been affected was not the basis for a hearing.⁸⁷

B. TORTIOUS INTERFERENCE

The court reviewed the exclusive contract and determined that it was a reasonable exercise of the board's power to provide proper management of the hospital.⁸⁸ The court also found persuasive the commonly cited arguments for entering into an exclusive arrangement for hospital-based physician services such as simplification of administering the anesthesiol-

77. *Gonzalez v. San Jacinto Methodist Hospital*, 880 S.W.2d 436 (Tex. App.—Texarkana 1994, writ denied).

78. *Id.*

79. *Jefferson Parish Hosp. Dist. No. 2 v. Hyde*, 466 U.S. 2 (1984).

80. 880 S.W.2d at 441-43.

81. *Id.* at 438-40.

82. *Id.* at 440-41.

83. 360 S.W.2d 895 (Tex. Civ. App.—Waco 1962, writ ref'd n.r.e.).

84. 880 S.W.2d 438-39.

85. *Id.* at 439-40.

86. *Id.* at 440.

87. *Id.*

88. 880 S.W.2d at 441.

ogy department, assuring coverage of professional services, and standardization of procedures.⁸⁹

C. RESTRAINT OF TRADE

In following the *Jefferson Parish*⁹⁰ case, the court determined that the impact on the market place rather than the impact on the ability of the physician to practice was the issue to be resolved.⁹¹ Since Gonzalez presented no evidence of adverse effects on the availability of anesthesiology services to patients in the market place it found that there was no valid antitrust injury.⁹²

VI. EMPLOYMENT

A. DISCRIMINATION

The federal district court in *Johnson v. El Paso Pathology Group, P.A.*⁹³ found that a pathologist who was employed by an independent group of pathologists, and who also served as the hospital's medical director of the pathology department, could be considered an employee of the hospital as well as an employee of the pathology group.⁹⁴ Since Dr. Johnson was considered to be subject to joint employers, claims raised by Dr. Johnson of sexual discrimination against the hospital served as the basis for the hospital's liability.

The specific claims involved a hostile work environment, and her termination for refusing to accept a less desirable position than medical director. The determination that the hospital and group should be considered "joint employers" derived from the relationship between the hospital and group.⁹⁵ Considerable control by the hospital over the group existed both in the day to day operations of the pathology lab and in explicit contract language in a services agreement between them.⁹⁶

Among the various control factors that the hospital could exert over the group included the right to approve who the group hired and fired, the appointment of the hospital as the sole agent for numerous business matters including management and administration of the group's business affairs, and the right to approve the group's obligations exceeding \$1000.⁹⁷ This amount was small compared to annual revenues of the group which generally exceeded \$1,000,000.⁹⁸ These factors taken to-

89. *Id.*

90. 466 U.S. 2 (1984).

91. *Id.* at 442.

92. *Id.* at 442-43.

93. 868 F. Supp. 852 (W.D. Tex. 1994).

94. *Id.* at 859.

95. *Id.* at 859-60.

96. *Id.*

97. *Id.* at 860.

98. *Johnson*, 868 F. Supp. at 860.

gether allowed the court to determine that both the group and the hospital could be considered joint employers for any member of the group.⁹⁹

B. EMPLOYEE LEASING

Legislation passed in 1993 requires the licensing and regulation of entities that engage in staff leasing.¹⁰⁰ This legislation permits a degree of dual control over the leased employee between the leasing company, often referred to as the "licensee," and the individual or entity which utilizes the benefit of the employee, often referred to as the "client."¹⁰¹

This is of particular significance in the health care field since many of these "employees" hold a license that requires some supervision by the client. Application of this arrangement could involve physicians employed by a non-profit health corporation,¹⁰² physician assistants employed by someone other than a physician,¹⁰³ or nursing or administrative staff provided to a physician's office by another entity such as a hospital. The licensee retains such rights as hiring, firing, disciplining, reassignment, employment, and safety policies.¹⁰⁴ For many purposes the dual control permits the client to retain supervision over the employee for those matters that relate to the employee's professional licensure.

There are, however, some areas of overlap that could be problematic. As an example, a physician assistant is supervised by a physician in the provision of health care services. When those services involve matters related to OSHA Bloodborne Pathogen Standards, the licensee's right to control safety policies could permit it to exercise control.¹⁰⁵

C. EMPLOYMENT OF LICENSED INDIVIDUALS

1. *Employment of Physician Assistants*

Legislation passed in 1993 created a separate licensing authority for physician assistants who were previously only authorized to act by the Medical Practice Act.¹⁰⁶ This new legislation does not restrict who may serve as an employer of a physician assistant — employers of physician assistants had previously been limited only to physicians.¹⁰⁷ There is the requirement, however, that if an individual or entity such as a health care facility employs a physician assistant, an arrangement must be made in which the physician assistant has a supervising physician.¹⁰⁸

99. *Id.*

100. TEX. REV. CIV. STAT. ANN. art. 9104 (Vernon Supp. 1995).

101. *Id.*

102. *See also supra* Part III.B.

103. TEX. REV. CIV. STAT. ANN. art. 4495b-1 (Vernon Supp. 1995); *see also infra* Part IV.C.

104. TEX. REV. CIV. STAT. ANN. art. 9104 § 7(a) (Vernon Supp. 1995).

105. Barton, *supra* note 3, at 44.

106. TEX. REV. CIV. STAT. ANN. art. 4495b-1 (Vernon Supp. 1995); *see also infra* Part XIII.B.3.

107. TEX. REV. CIV. STAT. ANN. § 16 (Vernon Supp. 1995); *see also infra* Part XIII.B.3.

108. TEX. REV. CIV. STAT. ANN. § 14 (Vernon Supp. 1995); *see also infra* part XIII.B.3.

2. *Employment of Physicians*

Legislation passed in 1993 permits a non-profit hospital or clinic or an organization that provides care to indigents to contract with a physician for medical services.¹⁰⁹ The entity may guarantee a salary to the physician, bill, collect, and retain the collections up to the amount of the salary and a reasonable amount related to collection services.¹¹⁰

D. EMPLOYMENT RELATED LIABILITIES

Facilities that employ mental health, chemical dependency, or rehabilitative care workers have a duty to inquire about the past history of any individual in their employment or being considered for employment regarding the individual's conduct that might be illegal, unprofessional, or unethical and that relates to the operation of the facility.¹¹¹ Specific liability is imposed in the area of sexual exploitation both for an employer's failure to inquire or for a former employer's failure to disclose information about a former employee's conduct.¹¹² The information to be disclosed may date as far back as five years from the occurrence of the sexual exploitation.¹¹³

VII. FRAUD & ABUSE

A. GENERAL

Legislation first enacted in 1991 dealt with the issue of the flow of benefits to or from a provider of health care services to another who was in a position to influence the referral of patients needing services.¹¹⁴ Commonly referred to as the "Illegal Remuneration Statute,"¹¹⁵ it was the basis for a wide sweeping investigation of psychiatric facilities by state and federal agents. The results of these investigations intensified interest in the area and yielded a number of amendments to this statute and to other sections of the Health and Safety Code (Code) involving operation of mental health, chemical dependency, and rehabilitation service facilities. The subsections that follow will address changes and new additions to the Code and a summary of the litigation involving the Texas Attorney General and various providers.

1. *Amendments to the Illegal Remuneration Statute*

The 1993 amendments¹¹⁶ expanded the scope of coverage of the Act by defining a "person" as anyone who pays or accepts a benefit from a per-

109. TEX. REV. CIV. STAT. ANN. art. 4495b, § 3.06(g)-(h) (Vernon Supp. 1995).

110. *Id.*

111. TEX. CIV. PRAC. & REM. CODE ANN. §§ 162.131-.132 (Vernon Supp. 1995).

112. TEX. CIV. PRAC. & REM. CODE ANN. § 81.002 (Vernon Supp. 1995).

113. *Id.* §§ 81.001-.009.

114. TEX. HEALTH & SAFETY CODE ANN. § 161.091 (Vernon 1992).

115. *Id.*

116. *Id.* §§ 161.091-.094 (Illegal Remuneration).

son licensed by a health care agency.¹¹⁷ It also created a rebuttable presumption that a violation had occurred if: (1) a person had referred or accepted a referral of a person to an inpatient mental health or chemical dependency treatment facility, (2) a payment for outpatient services after discharge of the patient was made to the person making the referral, and (3) the payment was not returned if the services were not provided.¹¹⁸

The amendments also created an exemption for entities that qualified as a health care information service.¹¹⁹ The fifteen-part test requires various disclosures including any relationship between the health care information service and a health care provider or facility.¹²⁰

B. MENTAL HEALTH, CHEMICAL DEPENDENCY AND REHABILITATIVE SERVICES

1. Legislation

In addition to the illegal remuneration legislative amendments cited above that apply to all regulated providers, specific legislation was passed that applies primarily to mental health, chemical dependency, and rehabilitative care providers.

The Treatment Facilities Marketing Practices Act¹²¹ describes certain business practices involved in marketing that are considered violations of the Code. These prohibited practices include the following:¹²²

1. compensation based upon volume of patient referrals;

117. *Id.* § 161.091(a).

118. *Id.* § 161.091(b) (Vernon Supp. 1995).

119. TEX. HEALTH & SAFETY CODE ANN. § 161.0915 (Vernon Supp. 1995). The 15-part test involves numerous specific requirements for a health care information service (Service) to qualify for exemption. The Service must be offered by telephone without charge to the person calling. The Service may not initiate calls to prospective consumers and must not be influenced by a health care provider to direct consumers to any particular provider. The Service is to provide information about possible health care providers based upon certain criteria such as location, specialization, costs, payment arrangements among other criteria. The names of providers must be given on a non-discriminatory basis. The criteria and any questions the Service may ask the caller can not be accomplished in a manner that directs the consumer to a particular provider. The Service must identify all providers that meet the criteria specified by the caller in the geographic area indicated. The Service must disclose any relationship between it and any health care providers. The Service must maintain a customer service system that handles complaints and that monitors customer satisfaction. The Service is prohibited from (1) offering health care counseling services, (2) providing transportation to or from a provider's office, (3) advertising only for specific health care problems or health care providers, (4) charging health care providers a fee based upon the volume or value of referrals made from the Service to the provider, (5) excluding any provider from participation in its Service based upon the provider's specialty, (6) excluding a participant for any reason other than the participant's ability to maintain licensure, malpractice insurance, documented consumer dissatisfaction with the provider, adverse determinations of a peer review committee relating to the provider's professional or ethical conduct or termination of the agreement between provider and the Service, and (7) disclosing information identifying a consumer unless the consumer has authorized its release or the release is made in connection with an appointment with a health care provider.

120. *Id.*

121. *Id.* §§ 164.001-.014.

122. *Id.* § 164.006.

2. solicitation of patients by a referral source without disclosing the existence of a relationship with a treatment facility, if any exists;
3. the placement of an individual from a treatment facility in a public or private school or a state or local governmental entity if that individual is in a position to refer to the treatment facility (subject to specific permitted practices);
4. contracts for the referral of patients between a treatment facility and an intervention and assessment service unless that service is operated by the Texas Department of Mental Health and Mental Retardation, a county or regional medical society, a qualified mental health referral service (as defined in this section of the Code), or a non-profit organization involved with family violence, runaway children, or rape;
5. operation of an intervention and assessment service by a treatment facility unless the service discloses to each person contacting the service of the relationship; and
6. advertisements that directly or indirectly promise a cure or guarantee treatment results including unsubstantiated claims.

For notes on the Illegal Remuneration Statute, see Part VII.A. above regarding the rebuttable presumption created when payments for referrals are made in connection with inpatient mental health services.¹²³

2. *Litigation*

Armed with legislation passed in 1993, the Attorney General vigorously pursued business practices in the psychiatric health service field state-wide. Suits were filed against health care providers, marketing firms, and management companies, with most resulting in settlements with the state and agreements to discontinue the particular practices. Most of the practices that were challenged involved payments from a provider either directly to a referral source or indirectly to a subcontractor who in turn made such payments. These practices were clear violations of the Illegal Remuneration Statute.¹²⁴ Other practices that were challenged involved compensation arrangements, typically between a hospital and a company that operated or managed a mental health unit for the hospital, in which the amount paid was based upon the number of patients or patient days. Although there is disagreement in the legal community whether payment practices based upon the number of patients or patient days violates the Illegal Remuneration Statute,¹²⁵ the defendant providers have most often settled with the state rather than litigate the issue.

123. *Id.* §§ 161.091-.094.

124. TEX. HEALTH & SAFETY CODE ANN. § 161.091(a) (Vernon Supp. 1995).

125. Health Law Section Meeting, State Bar of Texas Annual Convention, June 24, 1994; discussion among members of audience and staff counsel from Attorney General's office.

In *Texas v. BHC Richland Hospital Inc.*,¹²⁶ the hospital was charged with several violations related to marketing and referral practices. The Attorney General alleged that the hospital had hired a high school counselor to make referrals to the hospital in direct violation of the solicitation section of the Treatment Facilities Marketing and Admission Practices Act (Act).¹²⁷ The suit also contended that the management contract between the hospital and a firm hired to manage the hospital's psychiatric unit illegally compensated the firm based upon the number of patients maintained in the unit.¹²⁸ A further allegation claimed that the hospital's failure to disclose the marketing relationship misled patients in violation of the Act.¹²⁹ Although the settlement agreement did not contain any admission of wrongdoing by the hospital it did agree not to pay remuneration for securing referrals and to contract only with licensed mental health professionals.¹³⁰ Each of these requirements follow the illegal remuneration provisions of the Health and Safety Code.¹³¹

In *Texas v. Greeson*¹³² the Attorney General alleged that Greeson's marketing practices, which secured patients for Heights Hospital, did not meet the requirements for operating a qualified mental health referral service.¹³³ The marketing scheme, which did not utilize a psychiatric evaluation, involved a toll-free telephone number that persons interested in weight control could call. The marketing interviewer would determine the person's insurance coverage and recommend inpatient hospitalization for their weight condition. The outcome of this litigation was *not settled* at the time of publication of this Article.

In *Texas v. Texas Hotline, Inc.*¹³⁴ and *Texas v. Columbia Hospital Corp. of Houston*,¹³⁵ similar allegations of making payments for the securing of patients was the basis for the Attorney General's suits. The *Columbia* suit was settled with agreement to revise admission policies, advertising practices, and discontinue operation of assessment and referral services.

VIII. DEVELOPMENTS AFFECTING PAYORS OF HEALTH CARE

A. PROVIDER "Deselection"

The payment of health care most often involves an insurance company, health maintenance organization (HMO), preferred provider organiza-

126. No. 93-14941 (250th Dist. Ct., Travis County, Tex., Dec. 7, 1993) (order of dismissal and nonsuit signed on Mar. 3, 1994).

127. TEX. HEALTH & SAFETY CODE ANN. § 164.006 (Vernon Supp. 1995).

128. *Id.*

129. *Id.* §§ 164.001-.014.

130. See 3 Health L. Rep. (BNA) 306 (1994).

131. TEX. HEALTH & SAFETY CODE ANN. §§ 161.091-.094 (Vernon Supp. 1995)

132. No. 94-02411 (345th Dist. Ct., Travis County, Tex., Mar. 2, 1994) (final judgment May 20, 1994).

133. *Id.* (referring to TEX. HEALTH & SAFETY CODE ANN. § 164.007 (Vernon Supp. 1995)).

134. No. 94-02408 (261st Dist. Ct., Travis County, Tex., Mar. 2, 1994) (pending).

135. No. 94-02407 (250th Dist. Ct., Travis County, Tex., Mar. 3, 1994).

tion (PPO), or some other network arrangement that includes payors and providers. These relations frequently are based upon some form of participation agreement between the payor and provider. These participation agreements may be with individual providers, groups of providers, or with organizations comprised of different types of providers (physician-hospital organizations (PHO)). Because of the efficiencies of contracting with a number of providers, payors have increasingly turned to these groups for participation agreements. The agreements and membership in these groups are becoming a greater percentage of a provider's access to patients and revenue. These agreements and membership in the various organizations noted above do not, as a general rule, have elaborate "due process" protections for the providers in the event the provider is terminated ("deselected") or excluded from participation. Many of the agreements have "without cause" termination provisions that are exercisable by either party on relatively short notice. The cases discussed below represent initial efforts on the part of providers to develop some degree of legal precedent requiring due process.

In *Texas Medical Association v. Aetna Life Insurance Co.*,¹³⁶ the Medical Association was representing members of its organization who had been "deselected" from a preferred provider panel. The Association argued that the deselection threatened quality and continuity of care for the patients served by these doctors.¹³⁷ The notices that Aetna sent to the doctors indicated that the decision was based on business considerations and did not reflect on the quality of care the doctors provided. The suit was eventually dismissed by the court.¹³⁸

A similar suit was filed in *Texas Medical Association v. Prudential*,¹³⁹ which involved deselection of doctors in a preferred provider panel. In addition to the quality of care arguments made by the plaintiffs in *Aetna*,¹⁴⁰ the plaintiffs contended that they were entitled to due process rights under the Texas Administrative Code, which required a showing of the evidence used for deselection, and opportunity to refute the evidence and to present their own. Prudential indicated that the decision was an exercise of "business judgment" and relied on the "without cause" termination provision of the agreement. The case has been removed to federal court and is pending.

B. POLICY COVERAGE "MISREPRESENTATION"

In *Texas v. Kaiser Foundation Health Plan of Texas*,¹⁴¹ the Attorney General contended that Kaiser had misrepresented the coverage to be

136. No. Civ. A.H.-94-0288, 1994 WL 65477 (S.D. Tex. 1994).

137. 3 Health L. Rep. (BNA) 36 (Sept. 15, 1994).

138. *Id.*

139. No. 93-65003 (80th Dist. Ct., Harris County, Tex., Dec. 22, 1993) (removed to federal court on Dec. 29, 1993).

140. See *supra* note 137.

141. No. 94-08005 (98th Dist. Ct., Travis County, Tex., June 30, 1994) (notice of removal was filed Aug. 1, 1994).

provided under health insurance policies. Kaiser had allegedly denied to policy holders that their policies covered emergency care when the policy provisions did cover such care. The suit also claimed that Kaiser practices "unreasonably denied coverage or unreasonably delayed payment" on emergency care claims.

Kaiser responded that the group of claims that were the basis of the suit involved situations where the care received by the insureds was not covered by the insurance policy. In this instance which is common to HMO coverage, the plan does not pay for care rendered by a provider who is not part of the Kaiser network or which had not been pre-approved, unless a bona fide emergency existed; Kaiser contended that the suit was based upon a group of claims in which the primary issue was whether or not an emergency condition existed.

C. INSURANCE FOR INDIVIDUALS AND SMALL EMPLOYERS

The 1993 Legislature enacted the Small Employer Health Insurance Availability Act, which provided for the development of health benefits plans for employers with three to fifty employees.¹⁴² Three types of plans were authorized: (1) preventive and primary care which includes outpatient and limited inpatient care, (2) inpatient hospital coverage and limited outpatient coverage, and (3) standard benefits providing a range of services.¹⁴³ Employer requirements specify that seventy-five percent of the premium cost be paid by the employer and that at least ninety percent of the employees chose to be covered.¹⁴⁴ Insurance company requirements specify that small employers cannot be denied coverage due to claim experience, health status, or medical history.¹⁴⁵ The insurer also is limited in its ability to increase rates or adjust rates depending on the type of employer.¹⁴⁶ The legislation also provides for the formation of purchasing co-operatives,¹⁴⁷ requires that all health insurers utilize a uniform claim billing form, and requires that applications and policies be written in plain language.¹⁴⁸

D. DISCRIMINATION AGAINST OSTEOPATHIC HOSPITALS PROHIBITED

New provisions of the Insurance Code require that an HMO or a PPO permit an osteopathic hospital the opportunity to contract for services if it serves the area covered by the HMO and PPO and the cost for services is similar to other hospital providers.¹⁴⁹

142. TEX. INS. CODE ANN. art. 26.01-.76 (Vernon Supp. 1995).

143. *Id.* arts. 26.02(23) & 26.42-.50.

144. *Id.* art. 26.21(b).

145. *Id.* art. 26.72.

146. *Id.* arts. 26.31-.36.

147. TEX. INS. CODE ANN. arts. 26.11-.16 (Vernon Supp. 1995).

148. *Id.* art. 26.43.

149. *Id.* art. 21.53B.

IX. LIABILITY DEVELOPMENTS

A. EMERGENCY CARE

A provider's duty to render emergency health care is governed by several considerations. In the case of a licensed professional such as a physician, a duty exists if there is an existing patient-physician relationship. If no relationship exists, the physician may choose to enter into one on a "charity" basis as described below in the subsection dealing with the "Good Samaritan law"¹⁵⁰ or the usual form noted above. If the physician elects to participate on a hospital's emergency "on-call" list then the physician has, in essence, agreed to enter into a patient-physician relationship with those individuals who present to a hospital emergency department.¹⁵¹ The type of relationship the physician or any other licensed professional chooses to pursue dictates what duties will be expected of the provider. The cases below represent recent interpretations of some of these duties.

In *Pope v. St. John*¹⁵² a physician who was on call at a hospital was held to have assumed a legal duty to exercise ordinary care in the diagnosis of a patient who had presented at the hospital's emergency room.¹⁵³ The physician had responded to a call from the emergency room physician and attempted to diagnose on the basis of information supplied over the telephone.¹⁵⁴ In remanding to the trial court, the appeals court was persuaded that fact issues existed regarding whether appropriate testing had not been part of the diagnosis.¹⁵⁵

In *Hernandez v. Lukefahr*¹⁵⁶ a physician was permitted to utilize the "Good Samaritan" statute¹⁵⁷ as a defense.¹⁵⁸ The physician had responded to an emergency call for help while on the hospital premises.¹⁵⁹ The physician went to the emergency room to assist with a patient being resuscitated.¹⁶⁰ After no apparent success, the physician pronounced the patient dead.¹⁶¹ The patient subsequently showed some signs of life and was transferred to another hospital but died within a few days.¹⁶² The court determined that the physician fit within the requirements of the statute in that he (1) did not routinely provide care in the emergency room, (2) he did not expect to receive any compensation for the services

150. TEX. CIV. PRAC. & REM. CODE ANN. §§ 74.001-.002 (Vernon 1986 & Supp. 1995)

151. 59 Fed. Reg. 32,086 (1994).

152. 862 S.W.2d 657 (Tex. App.—Austin 1993, writ granted).

153. *Id.* at 661.

154. *Id.* at 659.

155. *Id.* at 661.

156. 879 S.W.2d 137 (Tex. App.—Houston [14th Dist.] 1994, no writ).

157. TEX. CIV. PRAC. & REM. CODE ANN. §§ 74.001-.002 (Vernon 1986 & Supp 1995).

158. *Id.* at 144.

159. *Id.* at 139.

160. *Id.*

161. *Id.* at 139.

162. *Id.* at 139-40.

provided, and (3) he was not shown to have been grossly negligent in his actions.¹⁶³

Another item of note is the "Good Samaritan" statute¹⁶⁴ which was enacted to encourage both medical and non-medical persons to render aid in a medical emergency. The standard of care is lowered to relieve some degree of liability for the actions of a "Good Samaritan."¹⁶⁵ The statute can be asserted as a defense if the individual rendering the aid does not receive compensation for the services rendered and has not acted with wanton or willful negligence.¹⁶⁶

Recent amendments clarify that the statute does not apply to certain individuals in the following circumstances:¹⁶⁷ (1) to the patient's admitting, attending, or treating physician, (2) to those personnel who routinely work in a hospital emergency room unless the person is in the emergency room area for reasons wholly unrelated to work (3) to those who would ordinarily be compensated for the care given in the particular situation, and (4) to a person whose negligent act or omission was a producing cause of the event.

B. HOSPITAL LIABILITY FOR PHYSICIAN ACTS

In *Berel v. HCA Health Services of Texas, Inc.*¹⁶⁸ a summary judgment for the hospital was reversed holding that the hospital could be held liable for the acts of a staff member's practice of medicine.¹⁶⁹ Acknowledging the body of case law holding that a hospital was not responsible for the acts of a physician under a master-servant theory the court decided that the nature of the right to control the details of the work of the physician could serve as such a basis.¹⁷⁰

The court found persuasive deposition testimony by the physician involved that control was exercised in the course of the hospital's quality assurance and utilization review committee activities.¹⁷¹ According to the physician these committees and the hospital's medical director could override a physician's medical orders.¹⁷² The court also examined language in the Mental Health Code¹⁷³ that requires a mental hospital to be "run by" a qualified physician who is held responsible for performing certain duties.¹⁷⁴ The court viewed these statutory requirements as forming

163. 879 S.W.2d 140-41.

164. See *supra* note 157.

165. 879 S.W.2d at 141.

166. See *supra* note 157.

167. See *id.*

168. 881 S.W.2d 21 (Tex. App.—Houston[1st Dist.] 1994, writ denied).

169. *Id.* at 23-24.

170. *Id.*

171. *Id.* at 24-25.

172. *Id.* at 24.

173. TEX. HEALTH & SAFETY CODE ANN. §§ 571.001, .007, 576.021-.022, 577.008 (Vernon 1992)(Texas Mental Health Code).

174. *Id.* at 25.

the basis for a nondelegable duty upon the hospital.¹⁷⁵ The deposition testimony and the statutory language, taken together, led the court to hold that there were fact issues to be considered at the trial court regarding the degree of control that would justify imposing liability on the hospital.¹⁷⁶

This case and any subsequent litigation that relies on *Berel* as precedent may represent an opportunity for plaintiffs to expand the ways in which a hospital could be held responsible for acts of a physician. The Texas Mental Health Code¹⁷⁷ imposes various duties upon a hospital with respect to its medical staff but permits a delegation of those duties to medical staff units of self-governance.¹⁷⁸ Whether these delegated functions will serve as the basis for imputing control by a hospital over a physician may serve to reshape these self-governance functions. Plaintiffs may be afforded an expanded basis for claims if this becomes a trend. Hospitals likewise should monitor whether a trend begins with this case to react in an appropriate manner regarding these physician self-governance functions.

The issue of negligent credentialing was the principal cause of action in *Lopez v. Central Plains Regional Hospital*,¹⁷⁹ that was reversed on appeal. The appeals court affirmed most of the summary judgment issues in favor of the hospital in the related malpractice claim but found that fact issues remained regarding the negligent credentialing claim.¹⁸⁰

There was conflicting evidence presented regarding the thoroughness of the assessment by both sides regarding the competency of the physician in question.¹⁸¹ In assessing the physician's capabilities in obstetrics the hospital had followed its policies closely, however, the appeals court believed that the evidence regarding the thoroughness of the assessment was subject to various interpretations.¹⁸² Although the hospital credentialing process did include obtaining letters of recommendation and evaluations from individuals who had worked with and supervised the applicant there remained the question whether the information allowed for a determination of "actual clinical competency."¹⁸³ The information reviewed did not address this specific issue and did not appear to ask those responding to evaluation requests about competence in the area of obstetrics.¹⁸⁴ This case not only reinforces negligent credentialing as a recognized cause of action but indicates an increasing degree of scrutiny of the process and the protection that the general public expects from hospital credentialing processes.

175. *Id.*

176. *Id.*

177. TEX. HEALTH & SAFETY CODE ANN. § 571.001 (Vernon 1992 & Supp. 1995).

178. *Id.*

179. 859 S.W.2d 600 (Tex. App.—Amarillo 1993, no writ).

180. *Id.* at 607.

181. *Id.* at 603-04.

182. *Id.* at 603.

183. *Id.*

184. *Lopez*, 859 S.W.2d at 603.

C. LIMITATIONS ON LIABILITY

1. *Application of Texas Torts Claim Act*

In *University of Texas Med. Branch at Galveston v. York*,¹⁸⁵ the court held that a patient's medical record is not tangible personal property.¹⁸⁶ This determination allows the medical branch to meet the requirements of the Texas Torts Claim Act¹⁸⁷ which requires that "a condition or use of tangible personal or real property"¹⁸⁸ be involved before a governmental entity can be held liable.

York's malpractice claim against the medical branch was based on alleged failure of hospital personnel to record information on the medical record that would have indicated the need for treatment.¹⁸⁹ In reversing an appeals court's affirmation of a trial court's finding of negligence, the Supreme Court of Texas held that while the paper of the medical record itself was tangible the information to be recorded was intangible.¹⁹⁰ The court further determined that there was no clear indication that the Legislature intended to impose governmental liability for the misuse of information.¹⁹¹

2. *HMO Not a "Provider" of Health Care*

In *Pickett v. CIGNA Healthplan of Texas*,¹⁹² the appeals court upheld precedent that an HMO is not liable for the acts of a physician providing care if the HMO did not directly employ, supervise, or contract with the physician.¹⁹³ The plaintiff filed a medical malpractice suit against CIGNA claiming that it was liable for the negligence of the treating physicians as its agents and that CIGNA had "held itself out" as a practitioner of medicine. The treating physicians were employees of a medical group that had an agreement with CIGNA. Since the physicians were under the control of that group and not CIGNA, the court determined that there was not a sufficient degree of supervision to consider the individual physicians as agents of CIGNA.¹⁹⁴

The court also analyzed the claim in view of the Medical Liability and Insurance Improvement Act of Texas¹⁹⁵ (commonly referred to as the "Malpractice Statute") and determined that the statute did not apply to a health maintenance organization¹⁹⁶ since it did not meet the statutory

185. 871 S.W.2d 175 (Tex. 1994).

186. *Id.* at 178-79.

187. TEX. CIV. PRAC. & REM. CODE ANN. § 101.021 (Vernon 1986).

188. TEX. CIV. PRAC. & REM. CODE ANN. § 101.021(2) (Vernon 1986).

189. *York*, 871 S.W.2d at 176.

190. *Id.* at 178-79.

191. *Id.* at 179.

192. 1993 WL 209858 (Tex. App.—Houston [1st Dist.] 1993, writ denied) (not designated for publication).

193. *Id.* at *3.

194. *Id.*

195. TEX. REV. CIV. STAT. ANN. art. 4590i §§ 1.01-15.01 (Vernon Supp. 1995) (Medical Liability and Insurance Improvement Act of Texas).

196. *Pickett*, 1993 WL 209858 at 2-3.

definition of a physician or a "health care provider" which includes "any person, partnership, professional association, corporation, facility, or institution duly licensed or chartered by the State of Texas to provide health care . . . or an officer, employee, or agent thereof acting in the course and scope of his employment."¹⁹⁷

X. MEDICAL RECORDS

A. CONFIDENTIALITY

The Fifth Circuit in *Gilbreath v. Guadalupe Hospital Foundation, Inc.*¹⁹⁸ upheld the preemption of state law¹⁹⁹ which protects medical records from discovery medical records.²⁰⁰ The release was required in connection with a federal civil service hearing involving a civil servant whose employment had been terminated. The court sought the medical records of the wife and son of the former employee who had allegedly attempted to murder both. The wife and son sought an injunction enjoining the production of the records. Even though a state court had entered a permanent injunction barring release of the medical records,²⁰¹ the proceeding was removed to federal court which determined that (1) the need for the medical records was pursuant to an authorized and proper investigation and (2) the documents sought were relevant to the investigation.²⁰²

B. TIME REQUIREMENTS

Amendments to the Medical Practice Act require that a physician must release the medical records within thirty days of an appropriately authorized request.²⁰³ Previous law remained intact which permits the physician to delete any part of the medical record that the physician believes would be harmful to the physical, mental, or emotional health of the patient.²⁰⁴ The amendments require that the physician state the reasons for not releasing the information.²⁰⁵ This confidentiality provision also allows the physician to delete confidential information about another person that may exist in the medical record.²⁰⁶ The amendments also expanded the manner in which summaries of medical records can be prepared including microfilm, computer means, or optical scanning devices.

197. TEX. REV. CIV. STAT. ANN. art. 4590i § 1.03(a)(3).

198. 5 F.3d 785 (5th Cir. 1993).

199. *Id.* at 791.

200. TEX. REV. CIV. STAT. ANN. art. 4495b § 5.08 (Vernon Supp. 1995) (Medical Practice Act).

201. 5 F.3d at 788.

202. *Id.* at 790-91.

203. TEX. REV. CIV. STAT. ANN. art. 4495b §§ 5.08(d),(k), (n) (Vernon Supp. 1995).

204. TEX. REV. CIV. STAT. ANN. art. 4495b § 5.08(k) (Vernon Supp. 1995).

205. *Id.*

206. *Id.*

C. HOSPITAL NOT REQUIRED TO PAY FOR COPY COSTS

In *Wiggs v. Fort Worth Osteopathic Hospital*,²⁰⁷ the appeals court upheld the trial court's finding that a hospital was not responsible to bear the cost of copying a patient's medical record. The plaintiff, who was preparing to file a medical malpractice claim, brought a declaratory action against the hospital seeking production of the records without payment. The trial court ruled that the provisions of the Medical Liability and Insurance Improvement Act²⁰⁸ were unambiguous and did not impose responsibility for costs of duplicating the records on the hospital.

XI. PATIENT'S RIGHTS

A. RIGHT TO TREATMENT

Although *In the Matter of Baby "K"*²⁰⁹ is merely persuasive authority, it may provide guidance for any hospital or other provider facing the issue of whether to provide treatment that it considers "futile." In this case, an infant was born with anencephaly, a congenital defect in which the cerebral cortex is absent or underdeveloped.²¹⁰ No treatment exists to cure, correct, or ameliorate the defect.²¹¹

The hospital sought to discontinue treatment over the mother's objections contending that any treatment would be futile. The court found that the infant enjoyed protection under the Americans with Disabilities Act of 1990 (ADA),²¹² Section 504 of the Rehabilitation Act (Rehab Act),²¹³ and the Emergency Medical Treatment and Active Labor Act (EMTLA).²¹⁴

In the ADA analysis, the court reasoned that Section 302(a) prohibits a public accommodation, including a hospital, from discriminating against an individual with a disability.²¹⁵ The discrimination was the denial of the use of a ventilator for the anencephalic infant where other infants needing a ventilator would have been provided that service.²¹⁶ The court reasoned that the hospital's rationale would lead to discrimination against an entire class of disabled individuals (i.e., anencephalic babies).²¹⁷ On a similar basis, the court's application of the Rehabilitation Act determined that, if Baby K were "otherwise qualified" to receive the use of a ventilator other than for the fact of the anencephaly, then withholding ventilator

207. No. 048-153-895-94 (48th Dist. Ct., Tarrant County, Tex., May 25, 1994) (pending).

208. TEX. REV. CIV. STAT. ANN. art. 4590i § 4.01 (Vernon Supp. 1995).

209. 832 F. Supp. 1022 (E.D. Va. 1993), *aff'd*, 16 F.3d 590 (4th Cir.), *cert. denied*, 115 S. Ct. 91 (1994).

210. 832 F. Supp. at 1025.

211. *Id.*

212. Americans with Disabilities Act of 1990, 42 U.S.C. §§ 12101-12213 (Supp. V 1993).

213. Rehabilitation Act of 1973, 29 U.S.C. § 794 (1988 & Supp. V 1993).

214. Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd (1988).

215. 832 F. Supp. at 1028-29.

216. *Id.* at 1029.

217. *Id.*

treatment from Baby K without parental consent would violate the Act.²¹⁸

Finally, the EMTLA requires that a hospital provide for "stabilizing" treatment which, in the case of Baby K, would include providing a ventilator.²¹⁹ The court rejected the hospital's contention that an exemption should apply since the stabilizing treatment would be futile and inhumane.²²⁰ This case represents one example of the many dilemmas facing health care providers, especially hospitals, in dealing with the issue of allocating limited resources.

B. MENTAL HEALTH CONSIDERATIONS

1. Patient Confidentiality

Legislation passed by the 1993 Legislature amending the Health and Safety Code creates a limited exception to the restriction on the release of medical record information from a mental health facility.²²¹ Unless a patient gives their attending physician contrary written instructions,²²² a treating physician may disclose the fact that the patient was, is, or is planning to be treated in a mental health facility.²²³ The disclosure may only be made if it is believed to be in the patient's best interest and only to a law enforcement officer or the patient's legally authorized representative.²²⁴ A legally authorized representative includes a parent or legal guardian, an agent under a durable power of attorney for health care, an attorney ad litem, or for a deceased patient a parent, spouse, adult, child, or personal representative.²²⁵

2. Patient Bill of Rights

That part of the Health and Safety Code dealing with mental health services was expanded by the Legislature to require that a "patient's bill of rights" be developed for use in facilities to protect the health, safety, and rights of a patient receiving voluntary or involuntary mental health, chemical dependency, or comprehensive medical rehabilitation services in an inpatient facility.²²⁶

A separate "Bill of Rights" was developed for adults, teenagers, and children.²²⁷ The adult version is the most elaborately written and includes specific freedoms that relate to the environment in which the care

218. *Id.* at 1028-29.

219. 832 F. Supp. at 1026-27.

220. *Id.* at 1027.

221. TEX. HEALTH & SAFETY CODE ANN. § 576.005 (Vernon 1995).

222. *Id.* § 576.005(c).

223. *See id.*

224. *Id.* § 576.005(b).

225. *Id.* § 576.005(d).

226. TEX. HEALTH & SAFETY CODE ANN. §§ 321.001-.004 (Vernon Supp. 1995).

227. 25 TEX. ADMIN. CODE § 404.162 (West 1994).

is provided.²²⁸ In addition to basic constitutional rights, adults are assured that: (1) treatment will be provided in the least restrictive setting, (2) any limitation of their rights will be reviewed at least every seven days, (3) communication privacy is maintained, (4) visitation access is not restrictive, (5) limitation on access to outdoors will be reviewed at least every three days, (6) unnecessary searches will not be conducted, (7) the patient's access to their own medical records is available subject to medically necessary limitations, (8) the right to refuse treatment, including medication, is clear, (9) a treatment plan is developed, and (10) physical restraints must be specifically ordered by a physician.²²⁹ For voluntarily admitted patients there is the right to leave the facility at any time unless a physician believes that emergency detention or court ordered services are necessary or if the patient is under the age of sixteen and the parent or guardian who agreed to the admission objects to the patient leaving.²³⁰

The teenager's version includes most of the same basic rights as in the adult version although in a much more abbreviated manner.²³¹ This version encourages communication with friends and family, requires that the patient be informed if any special observation is required, and requires explanation if physical restraint is used including the reason such restraint is required and when and why it will be removed.²³²

The children's version, "The Little Dinosaur Named Wilbur" is presented in coloring book format with large, easy to read text.²³³ It is designed to assure the child that he or she will have access to their games and toys, be able to play with other children, visit with friends and family, be able to call or write letters, and have the treating staff explain treatments and the plan of care.²³⁴ Supplementary materials to this version encourage the child to report things they do not like about the hospital to the hospital and their family.

3. *Other Rights for In-patient Mental Health Services*

The Health and Safety Code was amended at several provisions substantially expanding rights and protections to patients receiving in-patient mental health services. Among these expanded rights and protections are:

- A. rights to information on medications²³⁵ including identification of the drugs prescribed, conditions the medications are commonly

228. *Id.* at Exhibit A (four-page pamphlet entitled "Patient's Bill of Rights," published by and available from the Health Facility Licensure and Certification Division of the Texas Department of Health, 1-800-228-1570) (copy on file with author).

229. *Id.* at 2-3.

230. *Id.* at 3.

231. *Id.* at Exhibit B (two-page pamphlet entitled "Teen's Bill of Rights") (copy on file with author).

232. *Id.* at 2.

233. *Id.* at Exhibit C (pamphlet designed for children) (copy on file with author).

234. *Id.* at 5-17.

235. TEX. HEALTH & SAFETY CODE ANN. § 574.0415 (Vernon Supp. 1995).

- used to treat, beneficial effects of the medications, side effects and risks, and sources of further information on the drugs;²³⁶
- B. rights to communicate with a person outside the facility by telephone and by uncensored and sealed mail and to have any limitation on visitation and/or communication rights documented as to the clinical reasons for the limitation and the duration;²³⁷
 - C. rights to a court hearing when a patient refuses an order for psychoactive medications;²³⁸
 - D. access to a patient's own mental health record and an explanation if a professional denies access to any portion of the record;²³⁹ and
 - E. right to refuse treatment unless another individual has authority to make treatment decisions and right to informed consent including benefits, risks and alternatives to the treatment being considered.²⁴⁰

XII. PEER REVIEW AND RELATED ISSUES

A. PRIVILEGE OF CONFIDENTIALITY FOR PEER REVIEW AND MEDICAL COMMITTEES

Two statutory provisions govern the privilege of confidentiality of peer review proceedings. The Health and Safety Code as recently amended provides that the records and proceedings of a "medical committee" are confidential and not subject to court subpoena.²⁴¹ This protection is contingent upon the records and proceedings of the committee being used only in the proper exercise of committee function and that these are not records maintained in the ordinary course of business.²⁴² The other provision can be found in the Medical Practice Act²⁴³ which provides that "records or determinations of or communications to a medical peer review committee are not subject to subpoena or discovery"²⁴⁴

These two provisions were compared in *McAllen Methodist Hospital v. Ramirez*,²⁴⁵ in which a hospital sought to reverse a trial court's order requiring the release of various physician credentialing file information.²⁴⁶ The court noted that the Health and Safety Code (Code) provision was narrower than the Medical Practice Act provision (MPA) since the MPA applied to all information related to the peer review committee whereas the Code provision related only to the records and proceedings.²⁴⁷

236. *Id.* § 571.0065.

237. *Id.* § 576.006.

238. *Id.* §§ 574.101-109.

239. *Id.* § 611.0045.

240. *Id.* § 462.009.

241. TEX. HEALTH & SAFETY CODE ANN. § 161.032(a) (Vernon 1992 & Supp. 1995).

242. *Id.* § 161.032(b)-(c).

243. TEX. REV. CIV. STAT. ANN. art. 4495b § 5.06(g), (h) (Vernon Supp. 1995).

244. *Id.* § 5.06(j).

245. 855 S.W.2d 195 (Tex. App.—Corpus Christi 1993, no writ).

246. *Id.* at 197.

247. *Id.* at 197.

The court, in deciding whether to apply the broader MPA protection or the narrower Code provision, focused on the definition of a "medical peer review committee;"²⁴⁸ in particular its described function "to evaluate the quality of medical and health-care services or the competence of physicians."²⁴⁹ It also reviewed the definition of "medical peer review"²⁵⁰ and came to the conclusion that the privilege attaches to the review of physicians in the course of their practice at the hospital where the peer review committee functioned.²⁵¹ "The evaluation and review must relate to activities or occurrences at the hospital so that corrective or preventative measures may be taken."²⁵²

With these distinctions drawn, the court applied the protective privilege to peer review information for a physician already on staff but declined the privilege to information received in the course of a physician seeking membership to a hospital.²⁵³ Therefore the information contained in letters of recommendation and evaluation forms completed by those responding to requests for information should not expect the privilege to apply.

B. PRIVILEGE FOR JCAHO REPORT

In *Humana Hospital Corp. v. Spears-Petersen*,²⁵⁴ the San Antonio Court of Appeals determined that a hospital's Joint Commission on Accreditation of Healthcare Organizations (JCAHO) survey report could be protected from discovery in a medical malpractice suit.²⁵⁵ It held that the report was a product of a joint committee contemplated by the Health and Safety Code,²⁵⁶ that the disclosure of information on a voluntary basis to JCAHO did not constitute a waiver of privilege, and that the reports reflected a deliberative process of the organization with the purpose of improving patient care.²⁵⁷

C. PEER REVIEW IMMUNITY SUSTAINED

In *Maewal v. Adventist Health Systems*,²⁵⁸ the Fort Worth Court of Appeals upheld a trial court's summary judgment holding for a hospital and its physician peer review participants who were involved in a disciplinary action.²⁵⁹ In finding that the hospital and physicians qualified for the immunities afforded by the Health Care Quality Improvement Act of 1986

248. *Id.* at 198-99.

249. TEX. REV. CIV. STAT. ANN. art. 4495b § 1.03(a)(6) (Vernon Supp. 1995).

250. *Id.* § 1.03(a)(9).

251. 855 S.W.2d at 199.

252. *Id.*

253. *Id.* at 200.

254. 867 S.W.2d 858 (Tex. App.—San Antonio 1993, no writ).

255. *Id.* at 861.

256. TEX. HEALTH & SAFETY CODE ANN. § 161.031 (a)(2) (Vernon 1992).

257. 867 S.W.2d at 862.

258. 868 S.W.2d 886 (Tex. App.—Fort Worth 1993, writ denied).

259. *Id.* at 894.

(HCQIA)²⁶⁰ and the Texas Medical Practice Act (MPA),²⁶¹ the court determined that the hospital and its peer review participants had acted without malice and could be presumed to have met the requirements of HCQIA and the MPA.²⁶² Since the plaintiff presented no evidence to rebut the presumption, the immunities were applied by the court without a review of whether other requirements of HCQIA had been met.²⁶³

XIII. RIGHTS AND OBLIGATIONS OF PROFESSIONALLY LICENSED INDIVIDUALS

A. GENERAL

The 1993 Legislature enacted the Health Professions Council Act²⁶⁴ which, among other requirements, imposed upon all individuals licensed by a health licensing agency uniform rules governing advertising.²⁶⁵ "Advertising that is false, misleading, or deceptive or that is not readily subject to verification is declared unlawful"²⁶⁶ Advertising of this nature will subject a licensed individual to revocation or denial of his or her license and permits an action to be instituted by the consumer protection division of the Attorney General's office.²⁶⁷

The particular advertising activities proscribed include:

1. Makes a material misrepresentation or omission;²⁶⁸
2. creation of unjustified expectations about results or procedures;²⁶⁹
3. comparison with other like professionals unless the comparison can be substantiated;²⁷⁰
4. inclusion of testimonials;²⁷¹
5. causes confusion or misunderstanding regarding the credentials, education or licensure of a particular professional;²⁷²
6. offers to waive payment of deductibles or copayments;²⁷³
7. offers to accept insurance payment as payment "in full" regardless of whether a policy contains deductible or copayment requirements;²⁷⁴
8. claims that play upon the fears of susceptible persons; or²⁷⁵

260. Health Care Quality Improvement Act of 1986, 42 U.S.C. §§ 11101-11152 (1988 & Supp. 1993).

261. TEX. REV. CIV. STAT. ANN. art. 4495b § 5.06(b) (Vernon Supp. 1995).

262. 868 S.W.2d at 892-93.

263. *Id.* at 893-94.

264. TEX. REV. CIV. STAT. ANN. art. 4512p §§ 1-9 (Vernon Supp. 1995) (Health Professions Council Act).

265. *Id.* § 4.

266. *Id.* § 4(a).

267. *Id.*

268. TEX. REV. CIV. STAT. ANN. art. 4512p § 4(b)(1) (Vernon Supp. 1995).

269. *Id.* § 4(b)(2).

270. *Id.* § 4(b)(3).

271. *Id.* § 4(b)(4).

272. *Id.* § 4(b)(5).

273. *Id.* § 4(b)(6).

274. *Id.* § 4(b)(7).

275. *Id.* § 4(b)(8).

9. use of a professional title or designation that is expressly or commonly used by another type of licensed individual.²⁷⁶

However, these activities neither create a private cause of action nor provide a basis for breach of warranty or implied contract for workman-like service.²⁷⁷

B. PHYSICIANS AND PHYSICIAN ASSISTANTS

1. *Physician Requirements*

Amendments to the Health and Safety Code that relate to the prescription of controlled substances require (1) that the prescribing physician indicate the intended use of the drug unless the physician believes it is not in the best interest of the patient, (2) the name, address, and telephone number of the physician's place of business, (3) the DEA registration number of the physician, and (4) the quantity prescribed in both word and numerical form.²⁷⁸

2. *Complaint Procedures Related to Persons Licensed By the Texas State Board of Medical Examiners*

Persons regulated by the Texas State Board of Medical Examiners (SBME) which includes physicians, physician assistants and acupuncturists must meet requirements which enable patients to submit complaints to the SBME.²⁷⁹ These requirements involve the placement of notices in conspicuous places in the practitioners office, in the patient's statement, or in the registration form completed by the patient.²⁸⁰ The notice must inform patients how and where to make a complaint. It must be written in English and Spanish.²⁸¹

3. *Regulation of Physician Assistants*

The Physician Assistant Licensing Act (Act)²⁸² imposed new licensing requirements for physician assistants and established the Physician Assistant Advisory Council to advise the Texas State Board of Medical Examiners and to regulate the profession including all matters related to licenses.²⁸³ In addition to the typical duties of a licensing board, the Act delineated the scope of practice of a physician assistant to include:

1. obtaining patient histories and performing physical examinations;²⁸⁴
2. ordering or performing diagnostic or therapeutic procedures;²⁸⁵

276. *Id.* § 4(b)(9).

277. *Id.* § 4(c).

278. TEX. HEALTH & SAFETY CODE ANN. § 481.074(k) (Vernon Supp. 1995).

279. 19 Tex. Reg. 3328 (1994) (to be codified at 22 TEX. ADMIN. CODE § 188.1)

280. *Id.*

281. *Id.*

282. TEX. REV. CIV. STAT. ANN. art. 4495b-1 §§ 1-23 (Vernon Supp. 1995).

283. *Id.* §§ 4-5.

284. *Id.* § 12(b)(1).

285. *Id.* § 12(b)(2).

3. formulating a working diagnosis;²⁸⁶
4. developing and implementing a treatment plan;²⁸⁷
5. monitoring the effectiveness of therapeutic interventions;²⁸⁸
6. assisting at surgery;²⁸⁹
7. offering counseling and education to patients;²⁹⁰
8. requesting, receiving and signing for professional samples and distributing them to patients at a site serving medically underserved populations, as defined by statute or rule;²⁹¹ and
9. making appropriate referrals.²⁹²

The Act permits the employment of physician assistants by entities other than physicians²⁹³ but requires that the assistant be "supervised" by a physician and that the supervising physician share legal responsibility with the entity.²⁹⁴

C. NURSING

Amendments to the Professional Nurse Reporting Act²⁹⁵ include new provisions that relate to the following:

- A. reports required to be made must be written, signed, identify the nurse, indicate what corrective action was taken and recommend whether the Board of Nurse Examiners (Board) take formal disciplinary action;²⁹⁶ and
- B. when an employer or contractor takes an action against a nurse that involves reportable conduct and is effective for more than seven days a report to the Board must be made.²⁹⁷

Amendments to the Peer Review Act²⁹⁸ change the composition of a professional nursing peer review committee to include three-fourths of its members as registered nurses, only permit registered nurses to vote, if possible have at least one nurse in the practice field of the subject nurse, afford at least minimum due process including notice of the hearing and an opportunity for rebuttal.²⁹⁹

Additional statutes on specific areas were enacted in 1993 that relate to professional review activities involving nurses governed by the Board:

- A. penalties and sanctions;³⁰⁰

286. *Id.* § 12(b)(3).

287. *Id.* § 12(b)(4).

288. *Id.* § 12(b)(5).

289. *Id.* § 12(b)(5).

290. *Id.* § 12(b)(7).

291. *Id.* § 12(b)(8).

292. *Id.* § 12(b)(9).

293. TEX. REV. CIV. STAT. ANN. art 4495b-1 § 16 (Vernon Supp. 1995).

294. *Id.* § 17.

295. TEX. REV. CIV. STAT. ANN. art. 4525a §§ 1-16 (Vernon Supp. 1995) (Professional Nurse Reporting).

296. *Id.*

297. *Id.* § 2.

298. TEX. REV. CIV. STAT. ANN. art. 4525b §§ 1-7 (Vernon Supp. 1995) (Peer Review).

299. *Id.* § 1A.

300. TEX. REV. CIV. STAT. ANN. art. 4525.1 (Vernon Supp. 1995).

- B. complaint and investigation;³⁰¹
- C. agreed disposition;³⁰²
- D. rights of registered nurses;³⁰³
- E. initiation of formal charges;³⁰⁴ and
- F. hearings.³⁰⁵

D. PHARMACY

Amendments to the Texas Pharmacy Act³⁰⁶ include the following significant changes:

1. Pharmacists may administer medication under certain circumstances (1) when a licensed health care provider authorized to administer the medication is not available, (2) the failure to administer the medication could result in the interruption of a critical phase of drug therapy, (3) the pharmacist possesses the skill and education required to administer the medication, (4) the pharmacist notifies the health care provider responsible for the care of the patient, (5) the medication is not administered in the patient's residence unless a licensed nursing home or hospital, and (6) the pharmacist does not delegate this authority.³⁰⁷

2. Pharmacists may refill a prescription (unless it is a Schedule II controlled substance) without the authorization of the prescribing practitioner in the following circumstances:³⁰⁸

- A. failure to refill the prescription might interrupt a therapeutic regimen or create patient suffering;³⁰⁹
- B. either a disaster has occurred which prohibits the pharmacist from contacting the practitioner, or the pharmacist is unable to contact the practitioner after reasonable effort;³¹⁰
- C. the quantity dispensed does not exceed a 72-hour supply;³¹¹
- D. the patient is informed that the dispensing is without authorization and that future refills will require authorization from the practitioner;³¹² and
- E. the pharmacist informs the practitioner of the refill as soon as reasonably possible.³¹³

301. *Id.* art. 4525.2.

302. *Id.* art. 4525.3.

303. *Id.* art. 4525.4.

304. *Id.* art. 4525.5.

305. *Id.* art. 4525.6.

306. TEX. REV. CIV. STAT. ANN. art. 4542a-1 §§ 1-41 (Vernon Supp. 1995) (Texas Pharmacy Act).

307. *Id.* § 17(a)(5)(A)-(F).

308. *Id.* § 40B.

309. *Id.* § 40B(1).

310. *Id.* § 40B(2)(A),(B).

311. *Id.* § 40B(3).

312. *Id.* § 40B(4).

313. *Id.* § 40B(5).

XIV. RIGHTS AND RESPONSIBILITIES OF LICENSED FACILITIES

A. LICENSURE

1. Hospitals

A number of amendments in the Health and Safety Code (Code) relate to the licensing of hospitals by the Texas Department of Health.³¹⁴ These amendments became effective on September 1, 1993. Those of greatest general impact on the operations of hospitals are outlined below.

A. *Emergency Orders.*³¹⁵ The Health Commissioner is authorized to issue emergency orders against a hospital if the commissioner believes that a hospital is violating or about to violate Code provisions, rules, special license provisions, injunctions, or any other order of the Commissioner or enforcement procedure.³¹⁶ The Commissioner must notify a hospital prior to the issuance of such an order and afford the hospital an opportunity for a hearing.³¹⁷ The hearing must be held within 10 days of the hospital's receipt of the notice.³¹⁸

B. *Administrative Penalties.*³¹⁹ The Commissioner is authorized to assess administrative penalties against a hospital for violations of Code provisions, rules, special license provisions, Commissioner orders or enforcement procedures.³²⁰ The penalties, which may be assessed up to \$1000 for each day the violation occurs,³²¹ are subject to mitigating factors such as previous violations, seriousness of the violation, jeopardy to patient health, safety, or rights, good faith conduct of the hospital, and "other matters as justice may require."³²² Due process requirements including the Administrative Procedure and Texas Register Act are incorporated in this penalty provision.³²³ The Commissioner is authorized to penalize hospitals that do not adopt, implement, or enforce a patient transfer policy in accordance with section 241.047 of the Code.³²⁴ Failure to conform to requirements of sections 241.028 or 241.055 permit an aggrieved individual to seek injunctive relief.³²⁵

C. *Patient Transfers.* Amendments to the Code conformed licensing requirements to existing federal law with respect to informed consent and

314. TEX. HEALTH & SAFETY CODE ANN. §§ 241.001-123 (Vernon 1992 & Supp. 1995) (Hospitals).

315. *Id.* § 241.0531.

316. *Id.* § 41.0531(a).

317. *Id.*

318. *Id.* § 241.053(b).

319. *Id.* § 241.059.

320. *Id.* § 241.059(a).

321. *Id.* § 241.059(c).

322. *Id.* § 241.059(b)(1)-(5).

323. *Id.* § 241.059(d)-(r).

324. *Id.* § 241.055.

325. *Id.* § 241.056.

informed refusal of treatment.³²⁶ In particular the revisions require adoption of rules³²⁷ on the following:

- (1) written request from the patient or representative seeking a transfer;³²⁸
- (2) certification by a physician or qualified medical person in the physician's absence indicating the risks and benefits of the transfer;³²⁹
- (3) all reasonable steps must be taken by a hospital to obtain the informed refusal of treatment or transfer in the event the patient refuses such;³³⁰ and
- (4) acknowledgement of any contractual, statutory, or regulatory obligation that exists between a patient and a designated or mandated provider for the transfer of emergency or nonemergency patients.³³¹

D. *Standards and Issuance of Annual Licenses.* Code amendments³³² require the adoption of rules that attempt to achieve consistency between Medicare Conditions of Participation³³³ and standards of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). This same section also eliminated prior Code³³⁴ language that prohibited the adoption of minimum standards exceeding Medicare Conditions of Participation. Other Code amendments permit the issuance of an annual license without an annual inspection if the hospital is certified as meeting Medicare Conditions of Participation or is accredited by the JCAHO.³³⁵

E. *Inspections.* The Texas Department of Health is allowed to inspect or investigate, at any reasonable time, a facility, its books, records, and documents as it determines necessary to enforce the Code, and related requirements.³³⁶ The information that is obtained in connection with any such inspection or investigation must be maintained in a confidential manner by the Texas Department of Health.³³⁷

2. *Comprehensive Medical Rehabilitation Services*

Legislation passed in 1993 provided for the licensure and adoption of standards related to the provision of comprehensive rehabilitative services provided by someone other than an individual.³³⁸ The specific serv-

326. TEX. HEALTH & SAFETY CODE ANN. § 241.027 (Vernon 1992 & Supp. 1995).

327. 25 TEX. ADMIN. CODE §§ 133.101-102; *see also infra* Part XIV.B. for a discussion of federal patient transfer rules.

328. TEX. HEALTH & SAFETY CODE ANN. § 241.027(c)(1) (Vernon Supp. 1995).

329. *Id.* § 241.027(c)(2), (3).

330. *Id.* § 241.027(e).

331. *Id.* § 241.027(f).

332. TEX. HEALTH & SAFETY CODE ANN. § 241.026 (Vernon 1992 & Supp. 1995).

333. 42 U.S.C. §§ 1395-1395ccc (1988 & Supp. V 1993).

334. Act of June 13, 1993, 73rd Leg., R.S. ch. 584, 1993 Tex. Sess. Law Serv. Sec. 4(b) (Vernon) (codified as an amendment to TEX. HEALTH & SAFETY CODE ANN. § 241.026).

335. TEX. HEALTH & SAFETY CODE ANN. § 222.024 (Vernon Supp. 1995).

336. *Id.* § 241.051 (Vernon 1992 & Supp. 1995).

337. *Id.* § 241.051(a).

338. TEX. HEALTH & SAFETY CODE ANN. §§ 241.121-.123 (Vernon 1992 & Supp. 1995) (Medical Rehabilitation Services).

ices to be governed by these provisions involve those that are “designed to improve or minimize a person’s physical or cognitive disabilities, maximize a person’s functional ability, or restore a person’s lost functional capacity”³³⁹ A license is required if the services to be provided involve the supervision of a physician and are more intensive than nursing facility care and minor treatment.³⁴⁰

The legislation imposed the adoption of standards for the provision of rehabilitation services that include the following:³⁴¹

- A. a facility must have a medical director who is a licensed physician board certified or eligible for certification in a specialty related to rehabilitation;³⁴²
- B. medical supervision by a licensed physician must be available 24 hours each day;³⁴³
- C. therapy to be provided by a multispecialty team that has at least eleven specified capabilities;³⁴⁴ and
- D. written treatment and continuing care plans must be developed by these multispecialty teams and provided to the patient and any designated representative.³⁴⁵

3. Home Health and Hospice Care

Legislation relating to home health and hospice care amended various provisions of the Code.³⁴⁶ These amendments consolidate for licensing purposes home health services, hospice care, and personal care into a single license for a “home and community support services agency” license.³⁴⁷ The Texas Department of Health (TDH) is permitted to deem licensing for entities that meet accreditation requirements of the Joint Commission on Accreditation of Healthcare Organizations, the Community Health Accreditation Program, or certified by a state agency whose standards meet or exceed requirements for licensing.³⁴⁸

Exemptions from licensing for these services include the following:³⁴⁹

- A. individual licensed professionals providing care in an institutional setting such as physicians, nurses, and dentists, among others;
- B. individuals providing services through a contract to a licensed entity;
- C. licensed entities that provide these services to their inpatients or residents;

339. *Id.* § 241.121.

340. *Id.* § 241.122.

341. *Id.* § 241.123.

342. *Id.* § 241.123(b)(1).

343. *Id.* § 241(b)(2).

344. *Id.* § 241.123(c).

345. *Id.* § 241.123(d)-(f).

346. TEX. HEALTH & SAFETY CODE ANN. §§ 142.001-.030 (Vernon 1992 & Supp. 1995) (Home and Community Support Services).

347. *Id.* § 142.002.

348. *Id.* § 142.006(c), (d).

349. *Id.* § 142.003.

D. individuals providing services pursuant to the Texas Workers Compensation Act; and

E. individuals hired directly by the client or their family.

TDH investigations of any agency licensed under this section are confidential and may only be released to a state or federal agency or law enforcement personnel, by authorized consent of patients involved, if required by law, or if in a form developed by TDH that does not identify specific individuals.³⁵⁰

B. PATIENT TRANSFER REGULATIONS

Regulations³⁵¹ implementing the Emergency Medical Treatment and Active Labor Act were published as interim rules on June 22, 1994 and became effective on July 22, 1994.³⁵² These regulations describe the responsibilities of hospitals and their staff to provide medical screening to individuals presenting at a hospital's emergency department, to stabilize their condition, and to transfer to another facility in an appropriate manner when necessary. Important aspects of the regulations including recent interpretations are outlined below.

1. *Facilities Subject to Regulations*³⁵³

The requirement to screen, treat, and transfer applies to hospitals that offer emergency services. Those facilities that do not offer emergency services must have procedures to deal with patients needing emergency services if they present at such a facility.

2. *When Services Must Be Rendered*³⁵⁴

In efforts to clarify when the regulations apply to a person's need for emergency medical care, this section defines that a person "comes to the emergency department" when the person is on the hospital property. Specifically excluded are patients in emergency medical transport vehicles who have contacted the hospital but have not been accepted for treatment unless the hospital owns or operates the transport vehicle involved.

3. *Medical Screening and Personnel*³⁵⁵

A medical screening must be performed on each individual who comes to the emergency department to determine whether an emergency exists and what treatment is necessary, if any, to stabilize the patient. The per-

350. *Id.* § 142.009(d).

351. 42 U.S.C. § 1395dd (1988 & Supp. V 1993).

352. 59 Fed. Reg. 32,086 (1994).

353. Provider Agreements under Medicare, 59 Fed. Reg. 32,086, 32,120 (1994) (to be codified at 42 C.F.R. §§ 489.20, 489.24(a)).

354. Provider Agreements under Medicare, 59 Fed. Reg. 32,086, 32,121 (1994) (to be codified at 42 C.F.R. § 489.24(b)).

355. Provider Agreements under Medicare, 59 Fed. Reg. 32,086, 32,120 (1994) (to be codified at 42 C.F.R. § 489.24(a)).

sonnel necessary to perform the screening must be "qualified medical personnel." Those physicians who serve on a facility's "on-call" list will define, in part, what the hospital's capabilities are for particular services.

4. *Stabilizing Treatment*³⁵⁶

Those services, including laboratory and related functions, that are customarily available to patients at the hospital must be utilized to stabilize a patient.

5. *Delay in Treatment*³⁵⁷

A hospital may not delay its screening or treatment of a patient in order to determine an individual's ability to pay for the services. If the hospital's routine registration process does not impede the patient's screening and potential stabilizing treatment it may include questions about the patient's ability to pay.³⁵⁸ This process, if undertaken, must be administered in a uniform manner to all patients in the emergency room area.³⁵⁹

6. *Conditions of Transfer*³⁶⁰

In the course of a transfer certain requirements must be met including necessary treatment during transfer, appropriate medical information, and acceptance by another hospital and physician for transfer purposes. It is not the transferring hospital's responsibility to provide transportation services but the particular needs of the patient must be determined by the transferring physician.

7. *Specialized Capabilities of Accepting Facilities*³⁶¹

A hospital that accepts a transfer must offer all of its routinely available services including those that are specialized such as burn units, shock-trauma units, neo-natal intensive care, or regional referral centers in rural areas. If a patient requires services beyond what a hospital has the capacity to offer it may decline the transfer. If the individual is a patient in a hospital outside of the United States it is not necessary for a hospital with specialized capabilities³⁶² to accept the patient.

356. Provider Agreements under Medicare, 59 Fed. Reg. 32,086, 32,121 (1994) (to be codified at 42 C.F.R. § 489.24(c)).

357. Provider Agreements under Medicare, 59 Fed. Reg. 32,086, 32,121 (1994) (to be codified at 42 C.F.R. § 489.24(c)(3)).

358. *Id.*

359. 59 Fed. Reg. at 32,099.

360. Provider Agreements under Medicare, 59 Fed. Reg. 32,086, 32,122 (1994) (to be codified at 42 C.F.R. § 489.24(d)).

361. Provider Agreements under Medicare, 59 Fed. Reg. 32,086, 32,122 (1994) (to be codified at 42 C.F.R. § 489.24(e)).

362. Although there is no regulatory detail that expands the description of what constitutes "specialized capabilities" at least one region office of the Health Care Financing Administration (HCFA) has interpreted the phrase to mean any service that is available at the

8. *Violations*³⁶³

If a hospital suspects that a violation has occurred it is required to report to the Health Care Financing Administration; failure to report could result in termination from the Medicare program for the hospital failing to make the report.

C. MENTAL HEALTH SERVICE ISSUES

1. *Marketing and Admission Practices*

The Treatment Facilities Marketing Practices Act³⁶⁴ (Act) was enacted to curb many of the abusive practices that led to investigations and litigation by the Attorney General in the mental health service industry. The Act affects marketing and referral arrangements, the manner in which representations are made to prospective patients, and the manner in which the intake, assessment, and admission procedures are handled.³⁶⁵

A. *Qualified Mental Health Referral Service.*³⁶⁶ Referral services have historically been operated by facilities or organized groups of licensed providers to inform the public of the availability of their services and to direct an inquirer to a specific provider. The abuses that occurred in the mental health service area resulted in the regulation of these referral services. To operate a qualified mental health referral service, the service must meet a number of requirements including:

- (1) the service may not exclude a potential participating (health care) provider due to that participant's affiliation or non-affiliation with other participants;
- (2) payments by a participant for the service may not be related to volume or value of referrals;³⁶⁷
- (3) participants may not be restricted in their ability to provide professional services and may not charge patients referred from a service at a higher rate than other non-service patients;³⁶⁸
- (4) referrals may only be made to facilities operated or maintained by the Texas Department of Mental Health and Mental Retardation;³⁶⁹
- (5) service must be staffed and assessments made by licensed mental health professionals;³⁷⁰
- (6) referrals are made on a rotational basis to at least three mental health professionals where possible;

accepting hospital and not available at the transferring facility. HCFA Region VI, Department of Health Standards and Quality, Dallas, Texas.

363. Provider Agreements under Medicare, 59 Fed. Reg. 32,086, 32,120 (1994) (to be codified at 42 C.F.R. § 489.20).

364. TEX. HEALTH & SAFETY CODE ANN. §§ 164.001-.014 (Vernon Supp. 1995) (Treatment Facilities Marketing And Admissions Practices Act).

365. *Id.*

366. TEX. HEALTH & SAFETY CODE ANN. § 164.007(a)(1) (Vernon Supp. 1995).

367. *Id.* § 164.007(a)(2).

368. *Id.* § 164.007(a)(3).

369. *Id.* § 164.007(a)(4).

370. *Id.* § 164.007(a)(6).

- (7) person's identity seeking referral may not be disclosed;³⁷¹
- (8) disclosure of relationship between service and those receiving referrals including fee payments and selection criteria;³⁷²
- (9) maintenance of records on disclosures;³⁷³
- (10) disclosure of tolls or fees to make inquiry to a referral.³⁷⁴

B. *Disclosures and Representations.*³⁷⁵ Specific information must be made available to a prospective patient prior to admission including (1) the estimated average daily charge for inpatient facility services (2) the fact that professional fees may be charged separately from facility fees, (3) the name of the possible attending professional and (4) a bill of rights.³⁷⁶

Specific representations that may not be made include:³⁷⁷

- (1) misrepresentation about insurance coverage available to the patient and the amount for which the patient will be responsible;³⁷⁸
- (2) statements about involuntary commitment related to leaving against medical advice unless made by a physician;³⁷⁹
- (3) statements that the patient's insurance company may deny payment if the patient leaves against medical advice;³⁸⁰
- (4) recommendation of admission to a mental health facility without the evaluation by a licensed physician;³⁸¹ or
- (5) recommendation of admission to a chemical dependency facility without the evaluation of a mental health professional.³⁸²

C. *Prohibited Acts.*³⁸³ A person or entity is prohibited from making claims that involve: (1) promises of cure or guarantees that can not be substantiated,³⁸⁴ (2) unsubstantiated claims,³⁸⁵ (3) the availability of intervention services unless they meet all statutory requirements,³⁸⁶ (4) failure to disclose relationships between entities soliciting patients and entities or individuals treating the patients,³⁸⁷ or (5) obtaining confidential information for the purpose of securing referrals.³⁸⁸

371. TEX. HEALTH & SAFETY CODE ANN. § 164.007(a)(7) (Vernon Supp. 1995).

372. *Id.* § 164.007(a)(8).

373. *Id.* § 164.007(a)(9).

374. *Id.* § 164.007(a)(10).

375. *Id.* § 164.009(b)-(e).

376. TEX. HEALTH & SAFETY CODE ANN. §§ 321.001-.004 (Vernon Supp. 1995). *See also supra* Part XI.B.2.

377. TEX. HEALTH & SAFETY CODE ANN. § 164.009 (Vernon Supp. 1995).

378. *Id.* § 164.009(b).

379. *Id.* § 164.009(c)(1).

380. *Id.* § 164.009(c)(2).

381. *Id.* § 164.009(d).

382. TEX. HEALTH & SAFETY CODE ANN. § 164.009(e) (Vernon Supp. 1995).

383. *Id.*

384. *Id.* § 164.010(1)(A).

385. *Id.* § 164.010(1)(B).

386. *Id.* § 164.010(2).

387. TEX. HEALTH & SAFETY CODE ANN. § 164.010(3) (Vernon Supp. 1995).

388. *Id.* § 164.010(4).

D. *Intake, Assessment, and Admission Processes.*³⁸⁹ A patient in the process of admission shall have certain explanations and determinations made including the following:

- (1) a review of the patient's finances and insurance benefits;³⁹⁰
- (2) an explanation of patient's rights;³⁹¹
- (3) an explanation of the facility's services and treatment processes;³⁹²
- (4) an appropriate assessment made by an appropriately licensed and credentialed mental health professional;³⁹³ and
- (5) acceptance for admission only after a signed physician's order and acceptance by facility administration.³⁹⁴

2. *Abuse, Neglect, or Unprofessional Conduct in Health Care Facilities*³⁹⁵

A. *Reports of Abuse, Neglect, or Unprofessional Conduct.* Amendments to the Health and Safety Code require an employee, volunteer, or any other person associated with the operation of an inpatient mental health facility or unit that provides comprehensive medical rehabilitation services who believes that the mental or physical well being of a patient receiving chemical dependency, mental health, or rehabilitation services may or will be affected by abuse or neglect to report the information to the agency that licenses the facility.³⁹⁶ If a health care professional believes that an employee or a facility has or will engage in the conduct described above, that person shall report the information to the facility's licensing agency.³⁹⁷

An employer of an employee who has made a report may not take retaliatory action against that employee without subjecting the facility to injunctive relief and actual and exemplary damages.³⁹⁸ Retaliation against an individual who is not an employee and who has made a report will subject the facility to injunctive relief and actual and exemplary damages including those based on mental anguish.³⁹⁹

B. *Sexual Exploitation.* A mental health services provider is liable to a patient or former patient if the patient suffers physical, mental, or emotional injury resulting from sexual contact, sexual exploitation, or therapeutic deception from the provider.⁴⁰⁰ A mental health services provider or employer has a duty to report if there is a reasonable cause to suspect

389. *Id.* § 572.0025(b)(d)(f).

390. *Id.* § 572.0025(b)(1).

391. *Id.* § 572.0025(b)(2).

392. TEX. HEALTH & SAFETY CODE ANN. § 572.0025(b)(3) (Vernon Supp. 1995).

393. *Id.* § 572.0025(c)-(e).

394. *Id.* § 572.0025(f).

395. *Id.* § 161.132.

396. *Id.* § 161.132(a), (b).

397. TEX. HEALTH & SAFETY CODE ANN. § 161.132(a), (b) (Vernon Supp. 1995).

398. *Id.* § 161.134.

399. *Id.* § 161.135.

400. TEX. CIV. PRAC. REM. CODE ANN. § 81.002 (Vernon Supp. 1995).

sexual exploitation or a patient has alleged such not later than 30 days after the allegation or the reasonable cause became known to any mental health licensing agency or the county prosecuting attorney.⁴⁰¹

XV. TAX RELATED DEVELOPMENTS

A. CHARITY CARE REQUIREMENTS OF NON-PROFIT HOSPITALS

Legislation passed in 1993⁴⁰² defines the duties of a non-profit hospital to provide charity care to its community. The legislation requires the hospital to plan for the delivery of charity care through a budgeted process that includes the development of a community benefits plan and the public disclosure of the results of the plan in an annual report to the Texas Department of Health (TDH).⁴⁰³ Failure to provide the charity care subjects the hospital to possible loss of exemption from ad valorem, franchise, and sales taxes.

1. *Community Benefit Standards*⁴⁰⁴

The legislation provides for four alternative standards that a hospital may choose to meet to maintain its tax exempt status:

- A. charity care including government-sponsored indigent care is provided at a level that meets the reasonable needs of the community, taking into account the hospital's available resources and the tax-exempt benefits that the hospital receives;⁴⁰⁵
- B. charity care including government-sponsored indigent care is provided in an amount equal to at least four percent of the hospital's net patient revenue;⁴⁰⁶
- C. charity care including government-sponsored indigent care is provided in an amount equal to at least one hundred percent of the hospital's tax-exempt benefits, excluding federal income tax;⁴⁰⁷ or
- D. prior to January 1, 1996, charity care and community benefits equal to at least five percent of the hospital's net patient revenue. Of this combined amount, at least three percent of the hospital's net patient revenue must have been provided to charity and government-sponsored indigent care patients.⁴⁰⁸ After December 31, 1995 the charity and government indigent care three percent standard increases to at least four percent.⁴⁰⁹

401. *Id.* § 81.006.

402. TEX. HEALTH & SAFETY CODE ANN. §§ 311.041-.048 (Vernon Supp. 1995) (Duties of Nonprofit Hospitals).

403. *Id.*

404. *Id.* § 311.045.

405. *Id.* § 311.045(b)(1)(A).

406. *Id.* § 311.045(b)(1)(B).

407. TEX. HEALTH & SAFETY CODE ANN. § 311.045(b)(1)(C) (Vernon Supp. 1995).

408. *Id.* § 311.045(b)(1)(D).

409. *Id.* § 311.045(b)(1)(E).

The legislation defines several terms that have varying meaning in the health care industry⁴¹⁰ including charity care,⁴¹¹ community benefits,⁴¹² government-sponsored indigent health care,⁴¹³ government-sponsored program unreimbursed costs,⁴¹⁴ and unreimbursed costs among other terms.

2. *Community Benefits Plan*⁴¹⁵

In addition to a mission plan for the hospital, the legislation requires that a community benefit plan be developed that includes at least the following:⁴¹⁶

- A. a method for assessing the plan's effectiveness that involves surveying the community;
- B. defined measurable objectives with completion dates; and
- C. a budget.

3. *Annual Report*⁴¹⁷

An annual report must be filed with TDH that includes the following: (1) the hospital's mission statement,⁴¹⁸ (2) an identification of the health care needs of the community that were utilized in developing the community benefits plan,⁴¹⁹ and (3) an itemization of charity care and community benefits in amounts and types of benefit.⁴²⁰ Failure to timely file the report subjects the hospital to a \$1000 a day penalty.⁴²¹ The hospital must make the report available to the public and notify the public of its availability.⁴²²

4. *Availability of Charity Care*⁴²³

To meet one of the legislation's purposes of making available charity care, a hospital must develop a means of accomplishing this purpose through the provision of information to those who may seek charity services and the development of policies and procedures related to admission of charity patients which would include an eligibility system involving income levels and federal poverty guidelines.⁴²⁴

410. *Id.* § 311.042(14).

411. *Id.* § 311.042(1).

412. TEX. HEALTH & SAFETY CODE ANN. § 311.042(2) (Vernon Supp. 1995).

413. *Id.* § 311.042(6).

414. *Id.* § 311.042(7).

415. *Id.* §§ 311.044(c).

416. *Id.* § 311.044(c).

417. TEX. HEALTH & SAFETY CODE ANN. § 311.046 (Vernon Supp. 1995).

418. *Id.* § 311.046(a)(1).

419. *Id.* § 311.046(a)(2).

420. *Id.* § 311.046(a)(3).

421. *Id.* § 311.047

422. TEX. HEALTH & SAFETY CODE ANN. § 311.046(c) (Vernon Supp. 1995).

423. *Id.* § 311.041.

424. *Id.* §§ 311.043(d), 311.046(c), (d).

5. Exemptions⁴²⁵

This legislation defines certain types of hospitals that are not subject to its requirements in whole or in part.

- A. Exempt hospitals include hospital authorities and districts and hospitals operated by cities or counties;⁴²⁶
- B. Exemptions that require continued planning or reporting include (1) those hospitals that do not charge patients or receive payments from other sources, (2) hospitals located in counties with a population less than 50,000 and that have been designated as a health professional shortage area, (3) hospitals designated as a Medicaid disproportionate share provider, and (4) hospitals located in Potter and Randall counties.⁴²⁷
- C. Exemption may also be granted to a hospital that demonstrates that (1) meeting the charity requirement would financially impact the hospital causing a violation of bond requirements, (2) compliance would jeopardize the hospital's continued operation, or (3) a disaster has forced the hospital to substantially reduce its operations.⁴²⁸

B. FEDERAL TAX EXEMPTION GUIDELINES RELATED TO PHYSICIAN RECRUITMENT

An agreement⁴²⁹ between the Internal Revenue Service (IRS) and the Hermann Hospital Estate (Hermann) provides guidelines that are instructive to hospitals that are exempt under Internal Revenue Code section 501(c)(3)⁴³⁰ with respect to physician recruitment. Although the agreement is specific to Hermann which operates Hermann Hospital in Houston, Texas it is perceived industry-wide as an indicator of how IRS will review business practices in this highly competitive aspect of health care.

The business practice of physician recruiting typically involves offering a number of incentives for a physician to locate his or her practice in an area associated with a particular hospital or clinic. The legal issues related to offering such incentives involve several areas including fraud and abuse (federal antikickback statute,⁴³¹ Stark II legislation,⁴³² the Texas illegal remuneration statute,⁴³³ commercial bribery,⁴³⁴ and federal tax exemption. The Hermann agreement, and this comment, relates to tax exemption, in particular, tax law regarding "private inurement."⁴³⁵

425. *Id.* §§ 311.042(9)(B), 311.043(c).

426. *Id.* § 311.042(9)(B).

427. TEX. HEALTH & SAFETY CODE ANN. §§ 311.042(9)(B), 311.045(b) (Vernon Supp. 1995).

428. *Id.* § 311.043(c).

429. Hermann Hosp. Agreement, 3 Health L. Rep. (BNA), at 1519-24 (Oct. 20, 1994).

430. I.R.C. § 501(c)(3) (West 1994).

431. 42 U.S.C. § 1320a-7b (1988 & Supp. 1993).

432. 42 U.S.C. § 1395nn (Supp. V 1993).

433. TEX. HEALTH & SAFETY CODE ANN. §§ 161.091-.094 (Vernon Supp. 1995).

434. TEX. PENAL CODE ANN. § 32.43(b) (Vernon 1994)

435. I.R.C. § 501(c)(3) (West 1994).

1. *Community Benefit Requirement*

In order for Hermann to satisfy the IRS that its prospective handling of physician recruitment would meet the underlying purposes of a tax exempt, charitable organization it agreed that the following conditions would be followed in demonstrating community need for the physician:⁴³⁶

- A. a deficiency in the number of physicians to the population's need for that particular type of physician;
- B. a documented need for the particular medical service based upon the unavailability of the type of physician or lengthy delays in scheduling appointments;
- C. the area in which the physician is to be located is designated as a "Health Professional Shortage Area" as designated by the Department of Health and Human Services;
- D. a demonstrated difficulty in securing physicians to relocate to the area or hospital due to its location;
- E. an anticipated reduction in the number of physicians in a particular practice specialty that could be documented (for example, retirement); and
- F. a documented shortage of physicians serving indigent or Medicaid patients in the hospital's service area.

2. *Limitation on Incentives*

Under the agreement, permissible incentives can be grouped into two categories, those requiring repayment and those not requiring repayment.⁴³⁷

- A. Repayment is not expected for expenses such as actual moving expenses, relocation costs, and interview travel costs;
- B. repayment is not expected for other incentives in the form of subsidies for office space rental, overhead expenses, or equipment subsidies but only if there were no income guarantees to the physician;
- C. loans, lines of credit, and loan guarantees are permissible so long as the terms are representative of commercially available financing and repayment is made; and
- D. income guarantees must be reasonable in the amounts involved, limited to no more than two years, no incentives "off the agreement" and amounts advanced are to be treated as a loan to be repaid.

436. 3 Health L. Rep. (BNA) 1522 (Oct. 20, 1994).

437. *Id.* at 1523-24.