SMU | Dedman School of Law

SMU Law Review

Volume 50
Issue 4 *Annual Survey of Texas Law*

Article 14

1997

Health Care Law

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Recommended Citation
Larry A. Maxwell, et al., *Health Care Law*, 50 SMU L. Rev. 1275 (1997)
https://scholar.smu.edu/smulr/vol50/iss4/14

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HEALTH CARE LAW

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I. ADMINISTRATIVE RULE MAKING, LICENSURE, AND CERTIFICATION DEVELOPMENTS

A. TEXAS STATE BOARD OF MEDICAL EXAMINERS

1. 5.01(a) Corporations

THE Texas State Board of Medical Examiners (TSBME) issued proposed regulations[1] that were adopted without change effective January 12, 1996,[2] relating to non-profit corporations certified by

1. 20 Tex. Reg. 9246 (1995), *adopted* 21 Tex. Reg. 107 (1996) (to be codified at 22 TEX. ADMIN. CODE ch. 177) (Tex. Bd. of Medical Examiners, Certification of Non-Profit Health Corporations).
2. *See* 21 Tex. Reg. 107 (1996).

TSBME pursuant to section 5.01(a) of the Medical Practice Act (MPA).[3] These corporations, referred to in the health care industry variously as 5.01(a)'s, non-profit health corporations (NPHCs), or by the Texas Department of Insurance as approved non-profit health corporations (ANHCs), and referred to in this Article as ANHCs, provide several unique business alternatives not otherwise available in Texas. The regulations issued by TSBME relate to the business activity of an ANHC that employs physicians. Other than an individual physician or a professional association, the ANHC is the only type of entity that can employ physicians.

The regulations issued by TSBME affect, for the most part, the operation of an ANHC that has a non-physician member of the corporation. Although the rules pertaining to certification, recertification, and administrative reporting apply to all ANHCs, the TSBME imposed specific requirements and limitations on ANHCs with a non-physician member. For example, individuals who serve on the ANHC's board of directors (or trustees) must "actively practice medicine," which includes clinical practice; clinical medical research; supervision and training of medical students or residents; and professional managerial, administrative, or supervisory activities related to the practice of medicine or delivery of health care.[4] Additionally, non-physician members of the ANHC must obtain majority approval by the physician board of directors before they revise bylaws or appoint board members.[5] Only the board of directors may terminate a physician's employment with the ANHC[6] or adopt policies related to credentialing, quality assurance, utilization review, or peer review.[7] Should the non-physician member seek to terminate a physician's employment with an ANHC, the physician is entitled to due process.[8] TSBME has not indicated what constitutes due process other than requiring that the process be defined by a policy of the board of directors or contained in the contract between the employed physician and the ANHC.[9]

The new TSBME regulations further require biennial reports from an organization's CEO and each board director.[10] The CEO's report must

3. TEX. REV. CIV. STAT. ANN. art. 4495b (Vernon Supp. 1997).

4. 20 Tex. Reg. 9246 (1995), *adopted* 21 Tex. Reg. 107 (1996) (to be codified at 22 TEX. ADMIN. CODE § 177.3).

5. *Id.* (to be codified at § 177.5).

6. *Id.* (to be codified at § 177.4).

7. *Id.* Non-physician members of the ANHC may reserve authority without board approval for matters involving financial decisions including: capital, operating budgets, physician compensation and benefits, expenditure of funds, and managed care contracts in which the organization is at financial risk. *Id.*

8. *Id.*

9. *Id.* (to be codified at § 177.12).

10. Organizations seeking certification must submit information that is essentially the same as the biennial reports and the initial $2500 fee for certification. Thereafter, the biennial fee to maintain certification is $500. *Id.* (to be codified at § 177.7). An appeal process exists for organizations that have been denied certification or notified that a potential decertification may occur.

disclose corporate information such as the names and addresses of members of the corporation, officers, and directors, and whether there have been any revisions to the articles of incorporation or governing bylaws.[11] The biennial reports required from each board director must verify that the director: (i) continues to meet TSBME qualifications;[12] (ii) exercises independent medical judgment; (iii) will diligently cause the organization to comply with the MPA; (iv) will report to the TSBME any attempted violation of the MPA; and (v) has disclosed any financial relationship the director has with a member, other board member, or any entity that contracts with the organization.[13]

2. *Medical Records*

TSBME issued regulations[14] effective April 16, 1996,[15] relating to requests for patient records, conditions to the release of records, and maximum fees that can be charged for the production of the records. The request for records, which may be provided as copies or in a summary or narrative form, must be furnished within 30 days after the request and payment of a reasonable fee.[16] The physician may deny the request, but must provide a written statement of the reasons for denial.[17]

Exceptions to the rule permitting the withholding of records pending receipt of payment include circumstances involving emergency or acute-medical-care requests from another physician.[18] If these exceptions do not apply and payment has not been made within ten days of the request for records, the physician must notify the requesting party of non-payment and may continue to withhold the records.[19] The withholding of records may not, however, be predicated on the patient or the patient's authorized agent's failure to pay outstanding accounts due to the physician.[20]

3. *Standing Delegation Orders*

TSBME issued regulations[21] effective June 14, 1996,[22] expanding the scope of who may provide certain medical services in connection with a

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11. *Id.* (to be codified at § 177.6).
12. These include licensure and active practice.
13. 20 Tex. Reg. 9246 (1995), *adopted* 21 Tex. Reg. 107 (1996) (to be codified at 22 TEX. ADMIN. CODE § 177.6).
14. 21 Tex. Reg. 835 (1996), *adopted* 21 Tex. Reg. 3003 (1996) (to be codified at 22 TEX. ADMIN. CODE § 165.1).
15. *See* 21 Tex. Reg. 3003 (1996).
16. 20 Tex. Reg. 835 (1996), *adopted* 21 Tex. Reg. 3003 (1996) (to be codified at 22 TEX. ADMIN. CODE § 165.1(b)). Reasonable fees may not exceed $25 for the first 20 pages and $0.15 per page thereafter. *Id.* (to be codified at § 165.1(e)).
17. *Id.* (to be codified at § 165.1(c)).
18. *Id.* (to be codified at § 165.1(f)).
19. *Id.*
20. *Id.*
21. 21 Tex. Reg. 2628 (1996), *adopted* 21 Tex. Reg. 4995 (1996) (to be codified at 22 TEX. ADMIN. CODE §§ 193.2-.4, 193.8).
22. *See* 21 Tex. Reg. 4995 (1996).

written, standing delegation order. It also clarified and expanded the scope of circumstances in which such orders may be implemented. Previous regulations had authorized such orders to physician assistants. However, the new regulations expanded the scope to include "advanced practice nurses," defined to include a nurse practitioner, nurse midwife, nurse anesthetist, and clinical nurse specialist.[23] Carrying out or signing a prescription drug order was expanded to include the "telephoning in of an order" if part of a standing delegated order.[24] Protocols for implementing prescriptive drug authority must specify "dangerous drugs" that may not be prescribed in connection with such an order, and such protocols must take into account the training and experience of the nurse or physician assistant.[25]

The site at which a nurse or physician assistant may practice in connection with such orders was expanded to include a physician's primary practice site or a "facility-based practice."[26] The regulation, which previously authorized physician assistants to function at a medically underserved location, was expanded to authorize nurses to serve these locations. The new regulation also requires periodic review of the standing orders and the services provided under such orders.[27] In any of the preceding situations, other than a physician's primary practice site, documentation must be maintained indicating the physician's supervision of the nurse or assistant.[28] Additionally, TSBME may issue orders or protocols related to patient treatment in medically underserved areas by nurses or physician assistants.[29]

Other specialized forms of delegation authority were authorized for certified registered nurse anesthetists when such delegation is pursuant to facility policies or medical staff bylaws regarding the selection and administration of drugs and application of medical devices necessary to maintain a patient's physiological status.[30] Similarly, nurse midwives or physician assistants appropriately certified may administer controlled substances during intra-partum and immediate post-partum care.[31]

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23. 21 Tex. Reg. 2628 (1996), *adopted* 21 Tex. Reg. 4995 (1996) (to be codified at 22 TEX. ADMIN. CODE § 193.2).

24. *Id.*

25. *Id.*

26. *Id.* (to be codified at § 193.8(a),(j)). "Primary practice site" now includes a "location where the physician is physically present with the physician assistant or advanced practice nurse." *Id.* (to be codified at § 193.8(i)(2)(c)). As used in the phrase "facility-based practice," a "facility" is a licensed hospital or long-term care facility at which the physician serves as a medical director, chief of medical staff, credentialing committee chair, department chair, or a physician who consents to the request of a medical director or chief of medical staff to delegate prescriptive drug authority. *Id.* (to be codified at § 193.8(j)).

27. *Id.* (to be codified at § 193.8(b)(4)).

28. *Id.* (to be codified at § 193.8(c)).

29. *Id.* (to be codified at § 193.8(g)).

30. *Id.* (to be codified at § 193.8(k)(1)).

31. *Id.* (to be codified at § 193.8(l)(1)).

B. Texas Department Of Health

1. *Medicaid Provider Status Termination*

In *Texas Health Enterprises, Inc. v. Texas Department of Health*,[32] Texas Health Enterprises, a nursing home operator, appealed a decision that upheld the administrative determination to terminate the nursing home's Medicaid certification. The issue was whether the nursing home had the right to introduce into the appellate record the administrative agency record that had not been introduced into evidence at the trial court.[33]

The nursing home contended on appeal that the Administrative Procedure Act[34] was "directory" and not "mandatory" with respect to introduction of the administrative agency record in a judicial appeal.[35] After reviewing legislative history and a recent judicial opinion,[36] the appeals court determined that the form in which the administrative record was introduced was not dispositive.[37] The record could be introduced either in the statement of facts or as part of the transcript.[38] Since the nursing home had not introduced the administrative agency record in either form at the trial level, the appeals court held that it could not introduce the record on appeal.[39]

2. *Registration Requirements*

In *Corporate Leasing International, Inc. v. Groves*,[40] the appellee dentists obtained a declaratory judgment ruling that the lease between the appellant leasing company that owned a laser and the dentists who used and were in possession of it was illegal, void, and unenforceable because the leasing company had not registered the laser with state regulatory authorities. On appeal, the court reversed the declaratory judgment and rendered judgment for the leasing company.[41]

The court's reversal rested on its review of the Texas Regulations for the Control of Radiation.[42] The regulations clearly required the registration of the equipment for a person to use or possess "a source of radiation unless that person has a license, registration, or exemption from the department or commission."[43] The court noted that several parts of the regulations[44] referred to possession and use of laser products or installations as requiring registration, but were less clear regarding ownership

32. 925 S.W.2d 750 (Tex. App.—Austin 1996, writ requested).
33. *Id.* at 751-52.
34. Tex. Gov't Code Ann. § 2001.175(d) (Vernon 1997).
35. *Texas Health Enters.*, 925 S.W.2d at 752.
36. Nueces Canyon Consol. Indep. Sch. Dist. v. Central Educ. Agency, 917 S.W.2d 773, 775-77 (Tex. 1996).
37. *Texas Health Enters.*, 925 S.W.2d at 755.
38. *Id.* at 754-55 (citing *Nueces Canyon*, 917 S.W.2d at 775-76).
39. *Id.* at 756.
40. 925 S.W.2d 734 (Tex. App.—Fort Worth 1996, writ denied).
41. *Id.* at 739.
42. Tex. Health & Safety Code Ann. §§ 401.101-.119 (Vernon 1992 & Supp. 1996).
43. *Id.* § 401.101.
44. *Id.* § 401.104(a), (c).

and registration requirements.[45] In particular, the court cited sections 70.5(j) and 70.7,[46] which emphasized possession and use rather than ownership.[47] These provisions were persuasive to the court, which held that a nonpossessory, nonusing owner is not required to register the equipment.[48] With this finding, the appeals court awarded damages for nonpayment against the dentists who had not satisfied terms of the lease.[49]

C. Texas Department Of Human Services: Medicaid Intermediate Care Facility Provider Status Termination

In the case of *Bell v. Texas Department of Human Services*,[50] the Intermediate Care Facility for Mentally Retarded provider appealed a trial court decision upholding the Texas Department of Human Services (TDHS) administrative decision to terminate the provider's Medicaid certification. On appeal, the provider argued (1) that it did not receive due process at the agency level and (2) that the agency's decision was not supported by substantial evidence. While the second argument involved a review of the specific fact circumstances, the first argument related to a specific requirement of the Texas Medicaid program that permits the sanctioning of a provider without notice for conduct or omission of conduct involving a "pattern of repeated violations."[51]

The provider argued that due process was not provided since TDHS did not give notice of the repeated violations and, thus, did not afford an opportunity for correction as required in the Administrative Code. The appeals court reviewed the Administrative Code and determined that notice of a "pattern of abuse" is not required before TDHS could authorize termination.[52]

D. Texas Department of Insurance: Managed Care Regulations

The rules described below and implemented pursuant to Commissioner of Insurance Order No. 95-1201 were the result of Governor George Bush, Jr.'s veto of the Patient Protection Act.[53] The veto directed the Texas Department of Insurance (TDI) to promulgate rules to protect the interests of patients and physicians in matters related to managed health care.

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45. *Corporate Leasing*, 925 S.W.2d at 737-38.
46. *Id.* at 738.
47. *Id.*
48. *Id.* at 738-39.
49. *Id.* at 740.
50. No. 03-95-00594-CV, 1996 Tex. App. LEXIS 3814 (Tex. App.—Austin, Aug. 28, 1996, n.w.h.) (not released for publication).
51. *See* 40 Tex. Admin. Code § 79.2115(a)(5) (West 1996).
52. 1996 Tex. App. LEXIS 3814, at *11.
53. Tex. H.B. 2766, 74th Leg., R.S. (1995).

The Commissioner of Insurance adopted rules in November 1995 and March 1996 dealing with: (i) quality of care and fairness to patients and providers, referred to as Patient Protection I and Patient Protection II; (ii) ANHCs and the circumstances under which these organizations could enter into "risk contracting;" (iii) global risk sharing contracts between primary HMOs and ANHCs and primary HMOs and provider HMOs; and (iv) amendments to HMO financial accounting requirements. Each of these rules apply to HMOs; Patient Protection I and Protection II apply to HMOs and health insurance policies that incorporate preferred provider plans (PPOs).

1. Patient Protection I

A primary objective of the Patient Protection I[54] rules is to maintain quality of care and fairness to patients. This objective is addressed by provisions of the rule that provide for disclosure of benefits to prospective enrollees and insureds. Managed care plans must make available to prospective group contract holders (employers), enrollees, and insureds upon request understandable and readable information concerning benefits, providers, limitations, prior authorizations, emergency services, and other information specified in the rule in a standard form to be prescribed by the TDI.[55] This enables group contract holders, enrollees, and insureds to make informed comparisons among plans.[56]

The policy objectives of quality care and fairness to patients are also reflected in the provisions on retaliation. Managed care plans may not take retaliatory action against: (i) a group contract holder or enrollee because the group contract holder or enrollee, or person acting on behalf of the group or enrollees, has complained; or (ii) a physician or provider because the physician or provider has reasonably complained on behalf of an enrollee.[57]

Patient Protection I rules require managed care plans to provide reasonable advance notice to enrollees and insureds of the impending termination of a treating physician or provider from the network. Upon request by the treating physician or provider, the managed care plan must provide ongoing treatment for enrollees and insureds with special circumstances for up to ninety days after the effective date of termination of the treating physician or provider. PPOs must make a current list of preferred providers available to the insured upon termination of a participat-

54. 28 TEX. ADMIN. CODE §§ 3.3703, 11.204, 11.1500-.1501, 11.1601-.1602 (West 1996); 21 Tex. Reg. 2465 (1996) (to be codified as amended at 28 TEX. ADMIN. CODE § 3.3704); 20 Tex. Reg. 10740 (1995), *adopted* 21 Tex. Reg. 2465 (1996) (to be codified at 28 TEX. ADMIN. CODE § 3.3705); 21 Tex. Reg. 2467 (1996) (to be codified at 28 TEX. ADMIN. CODE §§ 11.1502, 11.1600).

55. 28 TEX. ADMIN. CODE § 3.3703 (West 1996).

56. 21 Tex. Reg. 2465 (1996) (to be codified as amended at 28 TEX. ADMIN. CODE § 3.3704), 21 Tex. Reg. 2467 (1996) (to be codified at 28 TEX. ADMIN. CODE § 11.600).

57. 20 Tex. Reg. 10740 (1995), *adopted* 21 Tex. Reg. 2465 (1996) (to be codified at 28 TEX. ADMIN. CODE § 3.3705(3)).

ing provider.[58] Moreover, managed care plans may not use any financial incentive or make payment to a physician or provider that acts as an inducement to limit medically necessary services.[59]

The issue of unfair and unreasonable denial of reimbursement for emergency care is addressed by managed care plans, which must demonstrate the plan will (i) pay for emergency care services performed by non-network physicians or providers at the negotiated or customary rate; (ii) cover any medical screening examination or other evaluation required by state or federal law necessary to determine if an emergency medical condition exists; (iii) cover necessary emergency care services to covered enrollees and insureds, including treatment and stabilization of an emergency medical condition; and (iv) approve or deny coverage of post stabilization care as requested by a treating physician or provider within the time appropriate to the circumstances relating to the delivery of services and the condition of enrollee, but in no case to exceed one hour.[60]

Managed care plans must submit data to the TDI concerning quality, costs, and access to health care. The plans must file or provide upon request to TDI certain information such as the identification of providers, their specialties, and locations; types of compensation arrangements with providers; and utilization review plans.[61]

Under Patient Protection I, enrollees have the right to select a network provider. The plan application form must include a space for the enrollee to make a selection of a primary care physician or primary care provider.[62] Enrollees also must have the opportunity to "select or change a primary care physician or primary care provider within the HMO delivery network of available primary care physicians and summary care providers."[63] However, an enrollee may not change the primary-care physician more than four times in any twelve-month period.[64]

Patient Protection I also involves fairness to providers since a stable provider network is believed to offer the best care to enrollees.[65] Application information must be made available to interested providers, and managed care plans must make information concerning the application process available to physicians and providers who wish to apply for admission to the plan.[66] Furthermore, written reasons must be offered for

58. 28 TEX. ADMIN. CODE § 11.1601 (West 1996); 21 Tex. Reg. 2465 (1996) (to be codified 28 TEX. ADMIN. CODE at § 3.3704).

59. 28 TEX. ADMIN. CODE § 3.3703; 11.1501 (West 1996).

60. *Id.* § 11.204(20); 21 Tex. Reg. 2465 (1996) (to be codified at 28 TEX. ADMIN. CODE § 3.3704).

61. 28 TEX. ADMIN. CODE § 11.204(18-19) (West 1996).

62. *Id.* § 11.1602.

63. *Id.*

64. *Id.*

65. *Id.* §§ 11.1601-1603, 3.3703; 21 Tex. Reg. 2465 (1996) (to be codified as amended at 28 TEX. ADMIN. CODE § 3.3704); 20 Tex. Reg. 10740 (1995), *adopted* 21 Tex. Reg. 2465 (1996) (to be codified at § 3.3705).

66. 28 TEX. ADMIN. CODE §§ 3.3703, 11.1601(a) (West 1996).

denial or termination of providers.[67] The rules do not prohibit plans from denying admission because the plan has sufficient qualified providers.[68]

Managed care plans must offer an advisory review panel to review, upon request, a decision to terminate a physician or dentist.[69] Plans may use existing review committees, but one member of the advisory review panel must be a physician or dentist with the same or similar specialty as the physician or dentist, if available.[70] Pre-termination review, however, is not required if there exists a risk of imminent harm to patient health.[71]

Managed care plans that use economic profiling must make available to physicians and providers upon request the economic profiles of that physician or provider.[72] Additionally, HMO capitation payments to a primary-care physician or provider must begin within ninety days of selection or assignment, calculated from the date of enrollment.[73] If selection does not occur, the HMO must reserve the capitation payable until a selection or assignment is made.[74] If an enrollee does not select a primary-care physician or provider, the HMO will assign a primary care physician or provider who is located in a zip code nearest to the enrollee's residence or place of employment.[75] An HMO may propose to the department an alternative capitation plan that provides for immediate availability and accessibility to a primary care physician or provider and adequately compensates the primary-care physician or provider for the risk assumed.[76]

2. *Patient Protection II*

Patient Protection II[77] regulations were implemented to address concerns regarding rights of providers in managed care contracting activities. These rules include a contract holder's right to cancel coverage. A contract holder may cancel the contract based upon material changes to any provisions required to be disclosed to contract holders or the enrollees by HMO rule or other law, after not less than thirty days written notice to the HMO.[78]

There are separate rules for HMOs and PPOs for referral to an out-of-network physician or provider if medically necessary covered services are not available. Under the HMO rule, if medically necessary covered services are not available through network physicians or providers, then the

67. *Id.* § 11.1601(b); 20 Tex. Reg. 10740 (1995), *adopted* 21 Tex. Reg. 2465 (1996) (to be codified at 28 TEX. ADMIN. CODE § 3.3705).
68. *Id.*
69. *Id.*
70. *Id.*
71. *Id.*
72. *Id.*
73. *Id.* § 11.1603(1).
74. *Id.*
75. *Id.* § 11.1603(2).
76. *Id.* § 11.1603(3)(a), (b).
77. 21 Tex. Reg. 2467 (1996) (to be codified at 28 TEX. ADMIN. CODE § 11.506).
78. *Id.*

contract must provide for referral of a non-network physician or provider upon the request of a network physician or provider. The HMO has a reasonable period of time after the network physician or provider requests the referral, and the HMO must fully reimburse the non-network physician or provider at either the usual and customary rate or an agreed upon rate. Before a request for referral is denied, each contract must provide for a review by a specialist of the same or similar specialty as the type of physician or provider to whom a referral is requested.[79]

The PPO rule provides that a health insurance policy that includes different benefits from the basic level of coverage for use of preferred providers must provide that "[i]f covered services are not available through preferred providers, the insurer must pay for medically necessary covered services by a non-preferred provider at the preferred provider level of benefits."[80]

With respect to HMO medicare advertising, any HMO that offers coverage to Medicare beneficiaries must file with the TDI copies of any advertisement produced by the HMO or its agents related to the Medicare coverage, and which is considered an invitation to inquire[81] or invitation to contract.[82] These advertisements must be filed for review for compliance with Texas law and consistency with other documents.[83]

Under Patient Protection II, there is no indemnification of an HMO for the HMO's negligence.[84] The HMO must also disclose to a patient "Hold Harmless" clauses in the written description of health care plan terms and conditions provided to prospective group contract holders and enrollees. The HMO must explain that, except as set forth in the plan description, network physicians and providers have agreed to look only to the HMO for payment of covered services.[85]

Finally, "a preferred provider contract must include a provision stating that the physician or provider agrees that if the preferred provider is compensated on a discounted fee basis, the insured may be billed based only on the discounted fee and not the full charge."[86]

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79. *Id.* § 11.506.

80. *Id.* § 3.3704.

81. An "invitation to inquire" is "an advertisement that has as its objective the creation of a desire to inquire further about the product, and that is limited to a brief description of the loss for which the benefit is payable." 28 TEX. ADMIN. CODE § 21.113(a) (West 1996).

82. An "invitation to contract," is an advertisement that is not an invitation to inquire or an institutional advertisement. *Id.* § 21.113(b).

83. *Id.* § 21.113; 21 Tex. Reg. 2467 (1996) (to be codified at 28 TEX. ADMIN. CODE § 11.603).

84. "A contract between an HMO and a physician or provider may not contain any clause purporting to indemnify the HMO for any tort liability resulting from acts or omissions of the HMO." 21 Tex. Reg. 2467 (1996) (to be codified at 28 TEX. ADMIN. CODE § 11.1502).

85. *Id.* (to be codified at § 11.1600).

86. 21 Tex. Reg. 2465 (1996) (to be codified at 28 TEX. ADMIN. CODE § 3.3705).

3. ANHCs[87]

The TDI has designated certain entities as being able to enter into specified types of risk contracts; one of these types of entities is the ANHC. Article 21.52F, section 2, of the Texas Insurance Code provides that an ANHC must maintain a certificate of authority issued by the TDI in order to arrange for or provide a health care plan to enrollees on a prepaid basis.[88] However, Article 21.52F does not apply to:

> (1) an [ANHC] that contracts to arrange for or provide health care services on a fee-for-service basis; (2) contracts entered into by a certificate holder to arrange for or provide health care services on a fee-for-service basis; or (3) an activity exempt from regulation under Section 26(f) of the Texas Health Maintenance Organization Act.[89]

Moreover, an ANHC that "arrange[s] for or provide[s] health care services on a risk-sharing or capitated risk arrangement *on behalf of a health maintenance organization* . . . is not required to obtain a certificate of authority."[90]

To obtain an ANHC certificate of authority, an applicant ANHC must comply with each requirement imposed on an HMO and maintain accreditation with either the National Committee on Quality Assurance or the Joint Commission on Accreditation of Health Care Organization's network accreditation program.[91] For an ANHC *provisional* certificate of authority, the Commissioner of Insurance shall grant the provisional certificate if the applicant ANHC complies with all requirements imposed on an HMO and applies for and diligently pursues accreditation.[92] A provisional certificate may not be granted if the ANHC has been denied accreditation.

In order to maintain a certificate of authority or a provisional certificate of authority, an ANHC must comply with all the appropriate requirements that an HMO must comply with under the Insurance and Administrative Codes,[93] and applicable state insurance laws and regulations.[94] The requirements to obtain and maintain a certificate of authority do not apply to ANHCs that "arrange for or provide only medical care

87. *See generally* part I.A.1 regarding statutory characteristics and regulatory developments for approved non-profit health corporations (ANHCs).

88. TEX. INS. CODE ANN. art. 21.52F, § 2(c) (Vernon 1997).

89. *Id.* ch. 20A.

90. *Id.* art. 21.52F, § 2(c) (Vernon 1996) (emphasis added).

91. 21 Tex. Reg. 2253 (1996) (to be codified at 28 TEX. ADMIN. CODE § 11.1702(a)).

92. *Id.* (to be codified at § 11.1702(b)).

93. TEX. INS. CODE ANN. ch. 20A (Vernon 1997); 28 TEX. ADMIN. CODE ch. 11 (West 1997). Agents of an ANHC certificate of authority or provisional certificate of authority holder are considered HMO agents and must comply with the requirements applicable to HMO agents. 21 Tex. Reg. 2253 (1996) (to be codified at 28 TEX. ADMIN. CODE § 11.1703). An ANHC with a certificate of authority or provisional certificate of authority under Insurance Code Article 21.52F and Title 28 of the Texas Administrative Code are subject to the same statutes and rules as an HMO and are considered an HMO for purposes of regulation and regulatory enforcement. *Id.* (to be codified at § 11.1704).

94. 21 Tex. Reg. 2253 (1996) (to be codified at 28 TEX. ADMIN. CODE § 11.1702(b)(1-3)).

as defined in the Insurance Code, article 20A.02(k)."[95]

4. Global Risk-Sharing Contracts—ANHCs and Provider HMOs

An ANHC or a "provider HMO"[96] may contract with a "primary HMO"[97] to provide full-risk pre-paid health services.[98] The TDI rules apply to any primary HMO which contracts for the ANHC to arrange for or to provide for, on its behalf, any health care services, other than medical care or ancillary medical services, on either a risk-sharing or capitated risk arrangement for the primary HMO as part of its delivery network; or to any provider HMO which agrees to arrange for or provide health care services on a risk-sharing or capitated risk arrangement as part of the primary HMO delivery network.[99] For global risk-sharing contracts between primary HMOs and ANHCs and between primary HMOs and provider HMOs, the primary and provider HMOs must comply with all of the following requirements.

First, the primary HMO is required to submit a monitoring plan to the TDI. This plan should set out the plan for ensuring that the ANHC or provider HMO can effectively provide timely and accurate reimbursement to all physicians and providers under the contract; and should show how the primary HMO will ensure the contracted HMO functions fully comply with all regulatory requirements.[100]

Second, the primary HMO is required to file the form of HMO/ANHC or HMO/HMO agreement with the TDI. This written agreement must include provisions whereby the ANHC or provider HMO cannot terminate the agreement without ninety days written notice, as well as provisions limiting the ANHC or provider HMO from billing or collecting from HMO members for covered services and a provision that states that nothing in the contract shall limit the HMO's authority or responsibility

95. *Id.* (to be codified at § 11.1702(d)). "Medical care" means furnishing those services defined as practicing medicine under section 1.03(8) of the MPA. TEX. REV. CIV. STAT. ANN. art. 4495b (Vernon Supp. 1997).

96. 21 Tex. Reg. 2253 (1996) (to be codified at 28 TEX. ADMIN. CODE § 11.2(b)(23)). "Provider HMO" is defined as "an HMO that contracts directly or indirectly through contracts or subcontracts with a primary HMO to provide or arrange to provide health care services on behalf of the primary HMO within an HMO delivery network." *Id.*

97. *Id.* (to be codified at § 11.2(b)(20)). A "primary HMO" is "[a]n HMO that contracts directly with, and issues an evidence of coverage to, individuals or organizations for the primary HMO to arrange for or provide a health care plan or a single health care service plan to enrollees on a prepaid basis." *Id.*

98. *Id.* (to be codified at §§ 11.2, 11.1604); TEX. INS. CODE ANN. art. 20A.02 (Vernon 1996). "Health care services" are

> any services, including the furnishing to any individual of pharmaceutical services, medical, chiropractic, or dental care, or hospitalization or incident to the furnishing of such services, care or hospitalization, as well as the furnishing to any person of any and all other services for the purpose of preventing, alleviating, curing, or healing human illness or injury or a single health care service plan.

TEX. INS. CODE ANN. art. 20A.02(i) (Vernon 1996).

99. 21 Tex. Reg. 2253 (1996) (to be codified at 28 TEX. ADMIN. CODE § 11.1604(a)).

100. *Id.* (to be codified at § 11.1604(a)(1)).

to comply with all regulatory requirements.[101]

The agreement must further include the ANHC's or provider HMO's acknowledgement that the primary HMO is required to comply with all regulatory requirements; the HMO may monitor and oversee the ANHC or provider HMO; and the HMO is entitled to take action to assure that the ANHC or provider HMO are in full compliance with regulatory requirements. The agreement must allow the primary HMO access to the ANHC's contracts with physicians and providers and "require the ANHC to provide the primary HMO, with evidence of both financial solvency and financial ability to perform, such as a certified financial audit of the ANHC conducted by independent certified public accountants, utilizing generally accepted accounting and auditing principles."[102] Finally, the agreement must include a provision where the ANHC or provider HMO provide, at least monthly to the primary HMO, the necessary data to comply with regulatory reporting requirements.[103]

Global risk-sharing contracts between the primary HMOs and ANHCs or provider HMOs also require the primary HMO to conduct an annual on-site audit of the ANHC or provider HMO. More frequent on-site audits are required upon indication of material non-compliance with all regulatory requirements. "Written documentation of each audit . . . shall be made available to Texas Department of Insurance or the Texas Department of Health upon request."[104] The primary HMO must promptly correct an ANHC's failure to comply with regulatory requirements relating to any delegated matters which are necessary for the primary HMO's

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101. *Id.* (to be codified at § 11.1604(a)(2)).

102. *Id.* (to be codified at § 11.1604(f)).

103. The reporting information that the ANHC or provider HMO must include:

(i) number of primary HMO enrollees served . . .;

(ii) form of the contracts and subcontracts between the ANHC and physicians and providers . . .;

(iii) copayments received by the ANHC or provider HMO;

(iv) summary of the amounts paid by the ANHC or provider HMO to physicians and providers;

(v) methods by which physicians and providers were paid by the ANHC or provider HMO (capitation, fee-for-services, or other risk-sharing arrangements);

(vi) utilization data;

(vii) summary of the amounts paid by the ANHC or provider HMO for administrative services relating to the primary HMOs;

(viii) time period that claims and debts related to claims owed by the ANHC or provider HMO have been pending;

(ix) information required for the primary HMO to be able to file claims for reinsurance, coordination of benefits and subrogation;

(x) provider-enrollee satisfaction data;

(xi) complaint data;

(xii) documentation of any inquiries and investigation of the ANHC or provider HMO, or any individual subcontracting physician or provider . . .; and

(xiii) any other data necessary to assure proper monitoring and control of the primary HMO delivery network by the primary HMO.

Id. (to be codified at § 11.1604(2)(G)(i-xiii)).

104. *Id.* (to be codified at § 11.1604(a)(3)).

compliance.[105]

5. *HMO Liabilities—Amendments to Accounting Requirements*

The Administrative Code imposed on HMOs certain reporting requirements that relate to accounting practices.[106] An HMO is required to report each liability incurred by the HMO on all financial statement or other reports filed with the TDI.[107] Each HMO is also required to clarify incurred claim liabilities. Incurred claim liabilities include "all liabilities and expenses relating to medical and health care services provided by HMO delivery network and non-network physicians and providers."[108] The accounting requirements disallow credit for any risk-sharing arrangement relating to out-of-service area or emergency care provided by non-network physicians or providers.[109]

E. Texas Workers Compensation Commission

During the Survey period, the Texas Workers Compensation Commission (the Commission) issued amendments to rules relating to (1) agreements and settlements;[110] (2) disclosure of provider financial interests;[111] and (3) medical fee guidelines.[112]

1. *Agreements and Settlements After Final Commission Order or Appeals Panel Decision*

Agreements that an insurance carrier or representative has reached after a decision of an appeals panel or a hearing officer has become final must be filed with the Commission. The filing must be at least thirty days prior to the earlier of (i) the date the agreement is sent to the parties for signature or (ii) the date the agreement is sent to a court for approval; and "no later than 10 days after a court approves the agreement or settlement."[113] This rule became effective February 2, 1996.[114]

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105. *Id.* (to be codified at § 11.1604(a)(4)).
106. *Id.* (to be codified at § 11.806).
107. *Id.* (to be codified at § 11.806(a)).
108. *Id.* (to be codified at § 11.806(b)(4)).
109. A non-network physician or provider is defined as "a physician or provider who has not directly or indirectly contracted with an HMO or an HMO's network physicians or providers to provide medical or health care services to the HMO's enrollees." *Id.* (to be codified at § 11.806(c)).
110. 20 Tex. Reg. 8580 (1995), *adopted* 21 Tex. Reg. 514 (1996) (to be codified at 28 Tex. Admin. Code § 147.11).
111. 20 Tex. Reg. 8572 (1995), *adopted* 21 Tex. Reg. 513 (1996) (to be codified at 28 Tex. Admin. Code § 134.100). The effective date of this regulation was February 2, 1996. *See* 21 Tex. Reg. 513 (1996).
112. 21 Tex. Reg. 2090 (1996), *adopted* 21 Tex. Reg. 2361 (1996) (to be codified at 28 Tex. Admin. Code § 134.201).
113. *Id.*
114. *See* 21 Tex. Reg. 514 (1996).

2. *Disclosure by Health Care Providers of Financial Interest in Referring Providers*

A health care provider who makes a referral of an employee-patient to another health care provider in which the referring provider owns a financial interest[115] greater than five percent must notify the Commission within thirty days of the referral.[116] The disclosure must include information about the referring provider, the referral source and the ownership percentage in the referral source.[117]

3. *Medical Fee Guidelines*

New medical fee guidelines were issued relating to reimbursement levels for medical services, durable medical equipment, and pharmaceuticals.[118] The new fee guidelines became effective April 1, 1996.[119]

F. TEXAS STATE BOARD OF EXAMINERS OF PSYCHOLOGISTS

In a letter opinion from the Office of the Attorney General[120] the Attorney General responded to a request from the Texas State Board of Examiners of Psychologists (the Board) regarding an apparent conflict between Senate Bill 667, enacted by the Texas legislature in 1995, and an existing rule of the Board (the Rule)[121] relating to the requirement of patient consent to the release of mental health records. The letter opinion stated that the legislation superseded the Board's interpretation of the Rule.[122]

As written on the date of the opinion, the Rule permits the release of patient information by means of a patient's written authorization, pursuant to a court order, or as otherwise required by applicable law.[123] The Rule is susceptible to more than one interpretation, and the Board's position was that patient authorization was needed when a subpoena was issued. In addressing the request, the Attorney General's office first reviewed that part of Senate Bill 667 which was codified in the Health and Safety Code,[124] and found that it did not require as an express condition the receipt of patient authorization. Therefore, a psychologist could comply with a subpoena without written authorization.

The Attorney General also examined the Texas Rules of Civil Evi-

115. "[F]inancial interest is defined as any legal or equitable interest including partnership interest, community property, or shares or bonds of a corporation." 20 Tex. Reg. 8572 (1995), *adopted* 21 Tex. Reg. 513 (1996) (to be codified at 28 TEX. ADMIN. CODE § 134.100(b)).
116. *Id.* (to be codified at § 134.100(a)).
117. *Id.*
118. *See* 21 Tex. Reg. 2361 (1996).
119. *Id.*
120. Op. Tex. Att'y Gen. No. DM-102 (1996).
121. 22 TEX ADMIN. CODE § 465.22(d)(3) (West 1996).
122. Op. Tex. Att'y Gen. No. DM-102 (1996).
123. *Id.*
124. TEX. HEALTH & SAFETY CODE ANN. § 611.006(a)(11) (Vernon Supp. 1997).

dence, in particular Rule 510[125] as it relates to compliance with a subpoena and the privilege of confidentiality. The permitted exceptions expressed in Rule 510 were seen as similar to the exceptions enumerated in the Health and Safety Code provisions. Thus, Rule 510 and the Code provisions were determined not to be in conflict.

The request included questions involving potential liability on the part of a psychologist in responding to a subpoena with respect to whether the psychologist should notify the patient of the attempt to obtain patient information, and whether it was the duty of the psychologist to assert the privilege of confidentiality through the process of seeking to quash the subpoena. The opinion did not offer specific answers, but acknowledged that courts in other jurisdictions imposed tort liability for the improper release of mental health records.[126] Similarly, the opinion stated that no authority could be identified that imposed an affirmative duty on the part of the mental health practitioner to invoke the motion to quash a subpoena process.[127] The opinion concluded that the facts and circumstances of each individual situation should dictate whether private counsel should be consulted and whether the patient should be notified of the particular information request.[128]

G. Professional Discipline

1. Prescription and Use of Unapproved Drugs

For two decades, Dr. Stanislaw Burzynski has waged a battle against state and federal regulators in defense of his controversial assertion that he should be allowed to prescribe unapproved "antineoplastons" for cancer patients. In the federal courts, he was enjoined in 1983 from shipping antineoplastons in interstate commerce without obtaining the prior approval of the United States Food and Drug Administration (FDA).[129] In 1997, he was tried on a 75-count federal indictment that charged that his continued use of antineoplastons violated the 1983 injunction, constituted mail fraud and violated federal food and drug laws.[130] After a twenty-day trial, the district court dismissed all thirty-four mail-fraud counts, and the jury failed to reach a verdict on the remaining forty-one counts.[131]

Meanwhile, TSBME pursued Dr. Burzynski in administrative proceedings and state court. TSBME alleged that his intrastate use of antine-

125. Tex. R. Civ. P. 510.
126. *Id.*
127. *Id.*
128. *Id.*
129. *See* Texas State Bd. of Medical Examiners v. Burzynski, 917 S.W.2d 365, 366-67 (Tex. App.—Austin 1996, writ requested).
130. *See* Melissa Fletcher Stoeltje, *Cancer Drug Tests the Law*, Hous. Chron., Jan. 7, 1997, at A13.
131. *See* Deborah Tedford, *Burzynski Acquitted of Fraud/Judge Declares Mistrial on Rest of the Charges*, Hous. Chron., Mar. 4, 1997, at A1. For a partial but fascinating glimpse of the extent of the litigation spawned by Burzynski's use of antineoplastons, see Trustees of the Northwest Laundry & Dry Cleaners Health & Welfare Trust Fund v. Burzynski, 27 F.3d 153, 155, 156 n.12, 159-60 (1994), *cert. denied*, 115 S. Ct. 1115 (1995).

oplastons, which was not the subject of the 1983 injunction or the 1997 prosecution, violated state law. Specifically, the board charged that Burzynski's use of antineoplastons violated section 431.114 of the Texas Health and Safety Code,[132] which the board alleged prohibits Texas physicians from prescribing drugs not approved by the FDA, even if the drugs are limited to intrastate uses only.[133] Although the administrative law judge rejected TSBME's position, TSBME concluded that Dr. Burzynski had violated section 431.114.[134] On review, the district court reversed TSBME and dismissed this count, along with all other counts brought by the board.[135] The court of appeals reversed.

The appellate court directed most of its opinion to the district court's conclusion that section 431.114 could not be violated by Burzynski because section 5.09 of the MPA permits physicians to prescribe and sell drugs that have not been approved by the FDA.[136] The court concluded that "section 5.09 was intended to allow a physician to supply drugs to a patient in immediate need without violating the provisions of the Texas Pharmacy Act" and that it "does not authorize physicians to dispense unauthorized drugs."[137] Although the United States Court of Appeals for

132. The Health and Safety Code provides that "[a] person shall not sell, deliver, offer for sale, hold for sale or give away any new drug unless . . . an application with respect thereto has been approved and the approval has not been withdrawn under section 505 of the [Food, Drug and Cosmetic] Act." Section 431.114 also requires that documentary proof of the FDA's approval be filed with the state commissioner of health if the product is manufactured in Texas. TEX. HEALTH & SAFETY CODE ANN. § 431.114 (Vernon 1992).

133. TSBME alleged that Burzynski's continued use of the unapproved drug also violated § 3.08(4)(A) of the Texas MPA. *See Burzynski*, 917 S.W.2d at 367. Section 3.08(4)(A) makes it a ground for discipline if a physician "commit[s] any act that is in violation of the laws of the State of Texas if the act is connected with the physician's practice of medicine." TEX. REV. CIV. STAT. ANN. art. 4495b, § 3.08(4)(A) (Vernon Supp. 1997). Although the court of appeals' opinion does not specifically address the merits of TSBME's allegations with respect to the MPA, its final resolution of this appeal reinstates the board's conclusion that Burzynski violated both § 431.114 of the Health & Safety Code and § 3.08(4)(A) of the MPA.

The board also alleged that Burzynski violated the false advertising statute, TEX. HEALTH & SAFETY CODE ANN. § 431.183(a)(2) (Vernon 1992), which states that "an advertisement of a drug or device is false if the advertisement represents that the drug or device affects neoplasms" or cancer. The district court dismissed this count on the ground that the statute is unconstitutional, *see Burzynski*, 917 S.W.2d at 366, but the court of appeals reversed, concluding that Burzynski's marketing brochure concerned an unlawful activity and was, therefore, unprotected commercial speech. *See id.* at 371.

134. *Burzynski*, 917 S.W.2d at 367.

135. *Id.*

136. Section 5.09 provides in relevant part:

> (a) A physician licensed to practice medicine under this Act may supply patients with any drugs, remedies, or clinical supplies as are necessary to meet the patients' immediate needs. This subsection does not permit the physician to operate a retail pharmacy without first complying with the Texas Pharmacy Act (Article 4542a-1, Vernon's Texas Civil Statutes).
>
> (b) Nothing in this section shall prohibit the physician from supplying pharmaceutical samples to the patient, free of charge, if, in the opinion of the physician, it is advantageous to the patient, in adhering to a course of treatment prescribed by the physician, to receive such pharmaceutical samples.

TEX. REV. CIV. STAT. ANN. art. 4495b, § 5.09 (Vernon Supp. 1997).

137. *Burzynski*, 917 S.W.2d at 368.

the Fifth Circuit had earlier reached the same conclusion,[138] this appears to be the first time a Texas state court has so held.

2. *Reinstatement Proceedings*

In *Ramirez v. Texas State Board of Medical Examiners*,[139] the Court of Appeals in Austin held that when considering applications for reinstatement of a medical license, TSBME must follow the procedures mandated by the state Administrative Procedure Act (APA)[140] for "contested cases."[141] In *Ramirez*, the board "considered written materials that were neither admitted into evidence nor provided to Ramirez before or during the hearing [and] did not enter findings of fact and conclusions of law in support of its order" denying Ramirez' application for reinstatement.[142] On appeal TSBME conceded that it failed to follow the procedures for a "contested case,"[143] but it argued that reinstatement hearings are not "adjudicative hearings" within the meaning of the APA and, therefore, they are not "contested cases" that require an evidentiary hearing.[144] The court of appeals disagreed, largely because of a 1993 amendment to the MPA[145] that made denials of reinstatement applications subject to judicial review. Although the APA does not expressly provide for an evidentiary hearing on such applications, the court ruled "that such a hearing is necessarily implied by the language of the [amendment]."[146]

3. *Dental License Revocation—Judicial Review*

When the legislature's conflicting statutory commands create a Catch-22 for litigants, it often takes the Texas Supreme Court to provide a solution. That is exactly what happened in *Simmons v. Texas State Board of Dental Examiners*[147] when the Dental Practice Act (DPA)[148] combined with the APA to prevent judicial review of a dentist's license revocation.

The DPA gives a dentist thirty days from the date of notice of revoca-

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138. *See Northwest Laundry*, 27 F.3d at 158. In this case, the plaintiff, an ERISA health insurance fund, claimed that by billing the fund for his "treatment" of covered cancer patients with antineoplastons, Burzynski had defrauded the fund and violated the terms of the health plan. In the course of affirming the district court's grant of summary judgment for the plaintiff, the court of appeals stated: "Reading the statutes together, we cannot conclude that . . . section 5.09 [of the Texas Medical Practice Act] authorizes Dr. Burzynski to do anything forbidden by Health and Safety Code § 431.114." *Id.* at 158.

139. 927 S.W.2d 770, 773 (Tex. App.—Austin 1996, no writ).

140. *See* TEX. GOV'T CODE ANN. ch. 2001 (Vernon Supp. 1997).

141. *See id.* §§ 2001.051-.178.

142. *Ramirez*, 927 S.W.2d at 771.

143. *Id.*

144. *See* TEX. GOV'T CODE ANN. § 2001.003(1) (Vernon Supp. 1997), which defines a "contested case" as "a proceeding, including a ratemaking or licensing proceeding, in which the legal rights, duties, or privileges of a party are to be determined by a state agency after an opportunity for adjudicative hearing."

145. *See* TEX. REV. CIV. STAT. ANN. art. 4495b, § 4.10(c) (Vernon Supp. 1997).

146. *Ramirez*, 927 S.W.2d at 772.

147. 925 S.W.2d 652 (Tex. 1996), *rev'g* 932 S.W.2d 541 (Tex. App.—Tyler, 1995).

148. TEX. REV. CIV. STAT. ANN. art. 4548h (Vernon Supp. 1997).

tion to seek review in district court.[149] The APA, on the other hand, requires the dentist in such a case to exhaust administrative remedies by filing a motion for rehearing,[150] and it gives boards up to forty-five days to act on a motion for rehearing before it is deemed overruled by operation of law.[151] Mindful of both requirements, Dr. Simmons filed his motion for rehearing with the State Board of Dental Examiners (SBDE) on the same day he was notified that the SBDE had revoked his license.[152] Ten days later, he petitioned the district court for judicial review of the revocation order; fourteen days later he moved to stay the judicial-review proceeding until the SBDE had taken action on his motion for rehearing, and the district court granted his motion. When his motion for rehearing was overruled by operation of law, Simmons moved to reinstate his judicial-review action in the district court. The district court denied the motion, granted the SBDE's plea to the court's jurisdiction, and dismissed the case,[153] and the court of appeals affirmed.[154]

The supreme court reversed and remanded the case to the district court for a trial on the merits. Reasoning that the DPA requires an aggrieved party to appeal before the board may have ruled on the motion for rehearing required by the APA, the court concluded that Simmons had done all he could to satisfy both statutes and was entitled to obtain judicial review in the district court.[155] The court distinguished the situation in *Simmons* from the case of *Lindsay v. Sterling*,[156] in which the licensing statute merely required that judicial review be sought within thirty days after the agency's action became final. Because the agency's action became final only after the agency had ruled on the required motion for rehearing, there was no conflict between the licensing statute and the APA. By contrast, the conflict in *Simmons* was unavoidable, and the supreme court resolved the conflict in favor of the aggrieved dentist. Until the legislature corrects the situation with an amendment to the DPA,[157] litigants in Dr. Simmons' situation will be permitted this slight exception to the time requirements of the APA.

149. *Id.* § 3(a).
150. *See* TEX. GOV'T CODE ANN. § 2001.145(a) (Vernon Supp. 1997).
151. *See id.* § 2001.146(c).
152. *Simmons*, 925 S.W.2d at 652.
153. *Id.* at 653.
154. Simmons v. Texas State Bd. of Dental Examiners, 932 S.W.2d 541 (Tex. App.—Tyler 1995), *rev'd* 925 S.W.2d 652 (1996).
155. *Simmons*, 925 S.W.2d at 654.
156. 690 S.W.2d 560 (Tex. 1985).
157. Texas Senate Bill 877 would delete the portion of section 3(a) that requires judicial review actions to be commenced within 30 days of notice of the Board's action. It would simply require that the right of appeal would be governed by the APA. Tex. S.B. 877, 75th Leg., R.S. (1997).

II. HEALTH BENEFITS

A. PREEMPTION OF STATE LAW

1. ERISA Preemption

Two recent federal cases occurring in Texas continued to apply the well-established federal preemption of state law claims under the provisions of the Employee Retirement Income Security Act (ERISA).[158] In the first of these cases, *Hermann Hospital v. Pan American Life Insurance Co.*,[159] the hospital sought payment from the insurance company for services provided to a patient who had been verified as having coverage with the insurance company. Subsequent to the provision of hospital services, the insurance company determined that the patient's coverage had expired several months before and refused to pay the hospital. Invoking its reliance upon insurance company personnel verifying the coverage, the hospital brought suit under a theory of negligent misrepresentation by the company.

The trial court relied on precedent from a number of cases holding that state claims arising from administration of a benefit plan are preempted by ERISA. The hospital argued that the insurance company's tortious conduct was independent and distinct from a wrongful denial of payments under the benefit plan. The court did not agree, distinguishing the hospital's claim from claims that were not preempted but only remotely affected by the plan.[160] The court further stated that a suit between two third-party suppliers to different parts of the benefit plan did not alter the relationship each party had to the plan and, therefore, preemption was appropriate.[161]

In the second Texas case involving ERISA, *Smith v. Texas Children's Hospital*,[162] a former hospital employee sued her employer claiming fraudulent inducement and breach of contract. Smith had changed employment to Texas Children's Hospital, relying in part on the hospital's representation that she would be able to obtain the long-term disability benefits which she had with her previous employer. An ensuing illness and claim for disability benefits was denied by the insurer on the basis of a pre-existing condition exclusion in the policy.

While the trial court determined Smith's other claims were preempted by ERISA, the fraudulent inducement claim was not preempted.[163] The hospital appealed the federal district court's remand to state district court regarding the fraudulent inducement claim. The federal appeals court agreed that Smith's claim for benefits under Texas Children's ERISA plan was preempted. Whether she was entitled to benefits at all was not a denial of benefits under such a plan, but was a question of whether Texas

158. 29 U.S.C. § 1144(a) (1994).
159. 932 F. Supp. 899 (S.D. Tex. 1996).
160. *Id.* at 901 (citing Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 100 (1983)).
161. *Id.* at 903.
162. 84 F.3d 152 (5th Cir. 1996).
163. *Id.* at 155.

law permits a plaintiff to recover for the value of benefits relinquished. The court determined that Smith's entitlement to benefits was a separate question from whether she was misled in believing she would be entitled to benefits.[164] Whether Smith was mislead into believing she would be entitled to benefits refers to what Texas Children's told her, while Smith's entitlement to benefits focuses on Texas Children's ERISA plan.[165]

2. *Federal Employees Health Benefit Act Preemption*

In a case similar to the preceding ERISA claims, *Transitional Hospitals Corp. v. Blue Cross and Blue Shield of Texas, Inc.*[166] involved claims by the hospital against the insurance company for breach of contract, negligent misrepresentation, and violation of state insurance law. The claims arose out of a denial of payment after the insurance company had confirmed coverage for a patient treated at the hospital.

The insurance company attempted to remove the case from state to federal court, arguing that the issues involved questions of federal law. On review, the federal district court applied Fifth Circuit precedent,[167] noting that a well-pleaded complaint that does not on its face state a substantial, disputed question of federal law may avoid removal by a defendant to federal court. The court acknowledged, however, that even an artfully drawn complaint that had no legitimate state cause of action could not survive removal to federal court. The court went on to apply the rule that a well-pleaded complaint must fall within "complete preemption" to qualify for removal.[168]

On the matter of complete preemption, the court noted that precedent established that it was not congressional intent that Federal Employee Health Benefit Act (FEHBA) preemption be applied as broadly as ERISA.[169] FEHBA preemption was considered to involve matters relating to the nature or extent of coverage or benefits to the extent that such matters were inconsistent with contractual provisions of the plan.[170] While FEHBA was acknowledged by the court to "broadly preempt state law," its scope was not complete and would not support conversion of a state claim to a federal claim permit removal to federal court.[171]

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164. *Id.* at 157.
165. *Id.*
166. 924 F. Supp. 67 (1996).
167. *Id.* at 69 (citing Carpenter v. Wichita Falls Indep. Sch. Dist., 44 F.3d 362 (5th Cir. 1995)).
168. *Transitional Hosps.*, 924 F. Supp. at 69.
169. *Id.* (citing Goepel v. National Postal Mail Handlers Union, 36 F.3d 306 (3d Cir. 1994), *cert. denied*, 115 S. Ct. 1691 (1995)).
170. *Id.* at 70 (citing 5 U.S.C. § 8902(m)(1) (1995)).
171. *Id.* at 70-71.

B. Determination of Benefits Under State Medicaid Program

In *Fred C. v. Texas Health and Human Services Commission*,[172] the central issue involved whether Fred, a 47 year-old resident of a nursing home, qualified under Medicaid for an augmentative communication device (ACD). This case of first impression applied Texas Administrative Code provisions that limited such devices to individuals under the age of 21,[173] and limited the scope of "covered" services.[174]

In reviewing the scope of services issue, the court noted that a state's participation in federally-supported Medicaid programs required certain minimum standards, including, but not limited to, inpatient hospitalization, outpatient hospital services, laboratory and X-ray services.[175] These "mandatory" services do not include speech related devices or ACDs. States may, however, offer optional services such as physical therapy and "related" services. Once these optional services are provided by a state, it is bound to offer optional services as defined by the Medicaid provisions of Title XIX of the Social Security Act.[176] Although the Texas Medicaid program had not elected to provide physical therapy and related services, it elected to provide home health care and prosthetic devices. The definition of home health care included durable medical equipment. While durable medical equipment was not defined in Medicaid terminology, the court agreed that the Texas Medicaid program terminology, which included "equipment that can withstand repeated use and is primarily and customarily used for medical purposes,"[177] was sufficient to encompass durable medical equipment and, therefore, the augmentative device fell within that description.[178]

On the issue of age, the court cited precedent in Arizona[179] and in the Fifth Circuit[180] to arrive at the conclusion that age was not rationally related to the denial of medical benefits to Fred.

III. MANAGED CARE DEVELOPMENTS

A. Any Willing Provider Issues

Legislation passed in 1995 is frequently referred to as the "Texas Any Willing Pharmacy Law."[181] In *Texas Pharmacy Association v. Prudential*

172. 924 F. Supp. 788 (1996).
173. *See* 25 Tex. Admin. Code § 33.112 (West Supp. 1996).
174. 25 Tex. Admin. Code § 33.112 (West 1996).
175. *Fred C.*, 924 F. Supp. at 790 (citing 42 U.S.C. § 1396d(a)(1), (2), (3), (17) (Supp. 1996)).
176. *See* Meyers v. Reagan, 776 F.2d 241 (8th Cir. 1985).
177. *Fred C.*, 924 F. Supp. at 791 (quoting Medicaid Providers Proc. Manual, p. 323).
178. *Id.* at 792.
179. *Id.* at 791 (citing Salgado v. Kirshner, 878 P.2d 659 (Ariz. 1994) (finding it unreasonable to deny medicaid funding on the basis of age)).
180. *Id.* (citing Curtis v. Taylor, 625 F.2d 645 (5th Cir. 1980) (Medicaid benefits distinctions must be made on a "rational basis.")).
181. *See* Tex. Ins. Code Ann. art. 21.52B (Vernon 1996).

Insurance Company of America,[182] the Pharmacy Association sought a declaration that Prudential was not adhering to the provisions of the new statute, which required that any willing pharmacy provider be allowed to participate as a contract provider if the pharmacy or pharmacist agreed to meet all the terms required by those pharmacies and pharmacists already under contract. Prudential countered that (1) the Association did not have standing to sue,[183] (2) the Association was improperly interpreting the statute,[184] and (3) the statute itself was invalid under ERISA.[185]

Finding the standing issue to be without merit, the court considered the only substantive issues to involve the interpretation of the statute and the ERISA preemption claim. The court rejected Prudential's contention that the "terms and requirements" section of the statute permits Prudential to exercise "reasonable business judgment" which would include the latitude to restrict the number of participating providers.[186] Taking a different view, the court interpreted the business judgment provision to apply to considerations such as economic, quality and accessibility.[187] The court went on to examine the stated "purpose" of the statute, which read, in part, "To prohibit a contractual provision in an insurance policy which interferes with or limits the participant's ability to choose his own pharmaceutical provider."[188] Likewise, the court rejected Prudential's contention that the previously existing administrative rules dealing with "preferred providers" modified the statute, reasoning that those rules relate to providers practicing medicine or the healing arts but not to pharmacies.[189]

On the ERISA issue, the court turned to precedent cited by the Fourth Circuit in *Stuart Circle Hospital Corp. v. Aetna Health Management*,[190] in dealing with Prudential's claim that the Texas statute relates to the business of insurance and is not within the savings clause of ERISA. Applying a two-pronged analysis of whether a statute fell within the savings clause, the court found that the statute met the first prong, requiring that the statute be clearly designed to regulate insurance contracts.[191] The court also found that article 21.52b met the three factors of the second prong: (i) the spreading of a policyholder's risk, (ii) in an integral part of the policy relationship, (iii) for a practice limited to entities within the insurance industry.[192] Having met both prongs of the test, the court concluded that the any willing pharmacy statute fell within the insurance sav-

182. Texas Pharmacy Assoc. v. Prudential Ins. Co. of Am., 907 F. Supp. 1019 (1995).
183. *Id.* at 1021.
184. *Id.* at 1024.
185. *Id.* at 1025.
186. *Id.* at 1024.
187. *Id.*
188. *Id.* (citing House Ins. Comm., Bill Analysis, Tex. H.B. 486, 72d Leg., R.S. (1991)).
189. *Id.* at 1025 (citing 28 TEX. ADMIN. CODE § 3.3701-.3705).
190. 995 F.2d 500 (4th Cir. 1993).
191. *Texas Pharmacy*, 907 F. Supp. at 1025.
192. *Id.* at 1025-26.

ings clause and, thus, was not preempted by ERISA.[193]

B. Vicarious Liability

In the case of *Jennings v. Burgess*,[194] the Texas Supreme Court affirmed a trial court's grant of summary judgment to a physician in a medical malpractice case. While the primary basis for upholding the trial court decision the statute of limitations, the concurring opinion by Justice Raul Gonzalez reviewed and confirmed a line of cases in Texas and other jurisdictions which hold that a physician is not negligent for "negligent referral" unless the referring physician fails to exercise reasonable care in making a recommendation.[195]

The concurring opinion also offered a glimpse of possible future judicial policy. Justice Gonzalez noted that the common theme among the negligent referral cases cited above is that there must be more than a referral alone, "there must be knowledge of incompetency or some other triggering factor."[196] Justice Gonzalez noted that current developments in the delivery of health care such as "managed care systems" and HMOs were diffusing the traditional chain of authority, implying that normal referral mechanisms may not be functioning in the patient's best interests.[197] If these issues are not addressed by the Texas Legislature in some comprehensive manner, Justice Gonzalez believes that the courts may be forced to "re-think" traditional notions of duty and standards of care to protect the interests of both victims of medical malpractice and physicians from frivolous litigation.[198]

IV. MENTAL HEALTH

A. Tort Liability in a Governmental Facility

In *Kerrville State Hospital v. Clark*,[199] a governmental hospital appealed its liability for damages resulting from the alleged negligent release of a patient, Gary Ligon, who murdered Rebecca Clark Ligon. The central issue in *Clark* was whether the hospital's administration of oral versus injectable medication fell within the waiver of sovereign immunity required to impose liability on a governmental entity.[200]

Rebecca's parents (the Clarks) contended that the administration of oral medication on an outpatient basis and the patient's failure to take the medication caused the patient's mental condition which lead to their daughter's murder. The Clarks argued that administration of the medica-

193. *Id.* at 1026.
194. 917 S.W.2d 790 (Tex. 1996).
195. *See id.* at 795 (Gonzalez, J., concurring). Several Texas cases have relied on this standard, most recently in Johnson v. Whitehurst, 652 S.W.2d 441 (Tex. App.—Houston [1st Dist.] 1983, writ ref'd n.r.e.).
196. *Id.* at 796 (Gonzalez, J. concurring).
197. *Id.*
198. *Id.*
199. 923 S.W.2d 582 (Tex. 1996).
200. *Id.* at 584.

tion by injection would have prevented the death. On this basis, the Clarks claimed that the hospital had "misused tangible personal property" in the treatment of patient Ligon. A condition or use of tangible personal or real property must be involved before a governmental entity can be considered to have waived its sovereign immunity.[201]

In reviewing other Texas cases which considered the issue of "use" and "non-use," the Texas Supreme Court determined that the decision of the hospital not to administer an injectable form of the medication was "non-use" rather than "misuse" and therefore did not constitute a waiver of sovereign immunity.[202]

B. Application of Official Immunity for Government Employees

In *Drogin v. Campbell*,[203] employees of San Antonio State Hospital sought to overturn a ruling against their summary judgment motion in favor of the administrator and family of the estate of a deceased patient of the hospital. *Drogin* involved a patient who committed suicide after being furloughed from the hospital. The estate and family claimed that the hospital and its employees were negligent in the release of the patient, who fell or jumped from a bridge two days after her release from the hospital. The estate alleged that a contributing factor in the patient's death was an attempted rape of the patient.

In seeking summary judgment, the employees sought "official immunity" under the Texas Mental Health Code.[204] The court reviewed the precedent set forth in *Kassen v. Hatley*,[205] which distinguished functions of the employees as either "governmental" or "medical." Governmental functions were accorded immunity, while medical functions were not.[206] The court of appeals agreed with the trial court's finding that medical functions were involved in the staff's handling of the patient's discharge, thus upholding the trial court's denial of summary judgement.[207]

As a side note to this case, which occurred in 1992, House Bill 383[208] which was passed in 1995, extended limitations on liability to governmental employees *except for providers of health care*.[209]

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201. *See* University of Texas Medical Branch v. York, 871 S.W.2d 175 (Tex. 1994).

202. *Kerrville*, 932 S.W.2d at 584.

203. 928 S.W.2d 205 (Tex. App.—San Antonio 1996, n.w.h.).

204. *See* Tex. Health & Safety Code Ann. § 571.019(a) (Vernon 1992).

205. 887 S.W.2.d 4 (Tex. 1994).

206. *See id.* at 11.

207. *Drogin*, 928 S.W.2d at 208.

208. Act of May 18, 1995, 74th Leg., R.S., ch. 139, 1995 Tex. Sess. Law Serv. 982 (Vernon).

209. *See* Stephen G. Wohleb, *Tort Reform and House Bill 383: How Public Servants in Health Care Were Left Out in the Cold*, State Bar of Texas Section Report Health Law 3 (Autumn 1996).

V. PEER REVIEW AND CONFIDENTIALITY DEVELOPMENTS

A. PEER REVIEW PRIVILEGE

In a series of cases decided by the Texas Supreme Court and handed down on July 12, 1996, the court clarified a number of issues related to the privilege of confidentiality for medical peer review records. Medical peer review records are accorded a privilege from discovery under several Texas statues, including the MPA and the Health and Safety Code.[210] In addition to clarifying what records are subject to the privilege, the court dealt with the issue of malice and whether it afforded a plaintiff any greater access to privileged records.

In *Memorial Hospital—The Woodlands v. McCown*,[211] the plaintiff, Dr. Bruce Leipzig, sued a television broadcast company claiming the he was defamed by a report that included information about him. As part of the discovery process, Leipzig requested information about his initial application for staff privileges and membership. The hospital sought to protect the records from production under the MPA and the Health and Safety Code. After being overruled at the trial court level, the hospital filed a mandamus action to the Texas Supreme Court.

In argument before the court, all parties agreed that peer review records generated in connection with a physician already on staff were protected. Therefore, the question was limited to the issue of records related to initial staff privileges and membership. The court's review focused on section 5.06(s)(3)[212] of the MPA and whether a hospital committee considering a physician's initial application for privileges and membership fell within the definition of a medical peer review committee as provided in the MPA. The court acknowledged the confidentiality of records of a medical peer review committee and determined that the functions of a hospital committee in considering the denial of membership or privileges are entitled to the same protection.[213] While not relying on the federal Health Care Quality Improvement Act (HCQIA),[214] the court noted that the initial "peer review in the initial credentialing process is an important part of the overall statutory scheme to improve the quality of medical care."[215]

The court rejected the argument that documents relating to initial credentialing were "records made or maintained in the regular course of business" and thus subject to discovery.[216] Records kept in the ordinary course of business were described as "records kept in connection with the treatment of [a hospital's] individual patients as well as the business and

210. TEX. HEALTH & SAFETY CODE ANN. § 161.032 (Vernon Supp. 1997).
211. 927 S.W.2d 1 (Tex. 1996).
212. TEX. REV. CIV. STAT. ANN. art. 4495b, § 5.06(s)(3) (Vernon Supp. 1997).
213. *Woodlands*, 927 S.W.2d at 3-4.
214. 42 U.S.C. 11101 *et seq.*
215. *Woodlands*, 927 S.W.2d at 6.
216. *Id.* at 7 (quoting TEX. HEALTH & SAFETY CODE ANN. § 161.032(c) (Vernon Supp. 1997)).

administrative files and papers apart from committee deliberations."[217] The court went on to reaffirm *Jordan v. Fourth Court of Appeals*,[218] which held that records "gratuitously submitted to a committee" or "created without committee impetus and purpose" would not be privileged.[219] In other conflicting decisions, the court disapproved of *McAllen Methodist Hospital v. Ramirez*,[220] *Family Medical Center, U.T. v. Ramirez*,[221] and *Riverside Hospital, Inc. v. Garza*,[222] to the extent they hold that no information relating to initial credentialing is privileged.

The next case handed down by the Texas Supreme Court, *Brownwood Regional Hospital v. The Eleventh Court of Appeals*,[223] dealt with a request for peer review information in a medical malpractice suit against a doctor and alleged negligent credentialing against the hospital.[224] At the trial court, a request for peer review information was denied on the basis of privilege under the MPA and the Health and Safety Code. On appeal, the court relied on *Riverside Hospital* to grant the requested relief. The Texas Supreme Court cited the *Woodlands* decision in reversing the appeals court decision.[225] Without making any distinctions from the *Woodlands* case, the court also noted that health care liability claims were not among the exceptions to discovery for peer review information.[226] Of the items sought by the plaintiffs, the court determined that hospital and medical staff bylaws were not protected from discovery, and further noted that information needed to support their case was available from other sources.[227]

The last of the cases, *Irving HealthCare System v. Brooks*,[228] was based on a lawsuit request for initial application information in which the plaintiff physician was claiming that false information was supplied intentionally and maliciously by the defendant in the course of the plaintiff's application for membership at other hospitals. The court cited the *Woodlands* case issued the same day for the proposition that the information sought was privileged and not discoverable.[229] The remaining issue was whether a claim involving malice would entitle the physician to discovery.

In ruling that no discovery should be permitted, the court examined provisions of the MPA which confer immunity and protection from dis-

217. *Id.* at 10 (quoting Texarkana Memorial Hosp. v. Jones, 551 S.W.2d 33, 35 (Tex. 1977)).
218. 701 S.W.2d 644 (Tex. 1985).
219. *Woodlands*, 927 S.W.2d at 10 (quoting *Jordan*, 701 S.W.2d at 648).
220. 855 S.W.2d 195 (Tex. App.—Corpus Christi 1993, no writ).
221. 855 S.W.2d 200 (Tex. App.—Corpus Christi 1993, no writ).
222. 894 S.W.2d 850 (Tex. App.—Corpus Christi 1995, no writ).
223. 927 S.W.2d 24 (Tex. 1996).
224. An interesting comment was made by the court in footnote 1, where the court wrote that it was not deciding whether a cause of action for "negligent credentialing" exists in Texas, nor the elements of such a cause of action. *Id.* at 26 n.1.
225. *Id.* at 26.
226. *Id.* at 27.
227. *Id.*
228. 927 S.W.2d 12 (Tex. 1996).
229. *Id.* at 15.

covery for peer review activities.[230] The court did not find any connection between immunity and discovery, and held that even where proof of malice would negate the immunities afforded the privilege from discovery, the two matters were separate and distinct.[231] Further support was cited in section 5.06(g) of the MPA, which specifically excepts anticompetitive or civil rights actions from the privilege of confidentiality, but not other causes of action.[232] As in *Brownwood*, above, the court observed that alternative sources of information were available to the plaintiff in preparing his case.[233]

B. Peer Review Immunity

In *Agbor v. St. Luke's Episcopal Hospital*,[234] the Agbors appealed a summary judgment in favor of the hospital in which the Agbors sued for medical malpractice by a doctor and negligent credentialing by the hospital. The trial court granted the hospital's motion based upon the assertion that the MPA provided an immunity from credentialing actions by a hospital absent a showing of malice.

In the course of rejecting the hospital's position and reversing the summary judgment, the appeals court examined provisions of the MPA, the HCQIA and their respective legislative histories. The court first found that section 5.06(*l*) and (m) of the MPA conferred immunities for peer review committee activities and its members, but did not extend to separate negligent acts of a health care entity.[235] Second, the court determined that an impossible burden would be placed on plaintiffs if a showing of malice was required before negligence could be established, since the proper application of privilege would limit access to much of the proof necessary to establish malice.[236] Third, the court compared provisions of the MPA incorporating the HCQIA,[237] and observed that HCQIA expressly provided[238] that it did not affect the rights and remedies available to patients.[239] In its final point, the court's examination of the legislative histories of both acts indicated that the intent was clearly to keep disgruntled physicians from suing peer review participants.[240] Based on these four findings the court held that the negligent credentialing claim was not barred by the immunities section of the MPA.[241]

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230. *Id.* at 16.
231. *Id.*
232. *See id.*
233. *Id.* at 18.
234. 912 S.W. 354 (Tex. App.—Houston [14th Dist.] 1995, no writ).
235. *Id.* at 357.
236. *Id. But see* Irving Healthcare Sys. v. Brooks, 927 S.W.2d 12 (Tex. 1996), in which the court observed that limited access to peer review records should not impose an undue burden since alternative sources of information was available to the plaintiffs.
237. Tex. Rev. Civ. Stat. Ann. art 4495b § 5.06(a) (Vernon Supp. 1997).
238. 42 U.S.C. § 11115(d) (1994).
239. *Agbor*, 912 S.W.2d at 358.
240. *Id.* at 359.
241. *Id.*

VI. PHYSICIAN CONTRACT RIGHTS

A. EXCLUSIVE CONTRACTING AND TORTIOUS INTERFERENCE

In the case of *Cavillo v. Gonzalez*,[242] the Texas Supreme Court applied recent precedent in reversing a court of appeals decision on the issue of tortious interference with business relations. The case involved Dr. Cavillo, who had an exclusive contract for anesthesiology services with San Jacinto Methodist Hospital, and Dr. Gonzalez, who had privileges at the hospital to practice anesthesiology. According to terms of the contract, Dr. Cavillo had sole authority to schedule anesthesia services and, after disagreements with Dr. Gonzalez, refused to schedule Gonzalez. Gonzalez filed suit against Cavillo and the hospital alleging numerous claims, including breach of contract, tortious interference with contract, tortious interference with business relations, civil conspiracy, and illegal restraint of trade.

The trial court rendered summary judgment in favor of the hospital and Cavillo on all claims. On appeal, that court upheld the summary judgment, but found that the defendant's motivations were fact issues that might bear on the claim of tortious interference with business relations. That decision was reversed by the Texas Supreme Court and rendered against Gonzalez.[243]

The supreme court applied *Texas Beef Cattle Co. v. Green*,[244] which held that a defendant's motivation behind the assertion of a legal right was irrelevant since the right itself established a defense of justification.[245] The court determined that the justification defense was applicable to claims of tortious interference in business relations both on an existing or prospective basis.[246] Following that reasoning, Cavillo's exclusive contract justified his interference with Gonzalez' prospects for business at the hospital and the issue of good faith was therefore irrelevant.

B. PROFESSIONAL SERVICE AGREEMENT AND WAIVER OF RIGHTS

In *Dillee v. Sisters of Charity of the Incarnate Word Health Care System*,[247] Dr. Dillee sued the hospital system alleging violation of constitutional and contract rights to due process in connection with the hospital system's termination of his professional services agreement. The professional services agreement contained a termination without cause provision as well as a provision in which Dillee specifically waived any due process rights to notice, hearing, or review in the event of termination of the agreement. The trial court granted summary judgment for the hospital system and Dillee appealed. On appeal, the court concluded that due process rights were waived and confined its review to the effectiveness of

242. 922 S.W.2d 928 (Tex. 1996) (per curiam).
243. *Id.*
244. 921 S.W.2d 203 (Tex. 1996).
245. *Cavillo*, 922 S.W.2d at 929.
246. *Id.*
247. 912 S.W.2d 307 (Tex. App.—Houston [14th Dist.] 1995, no writ).

the waiver.[248]

The court acknowledged that contract rights could be intentionally relinquished,[249] as could constitutional rights, so long as the waiver was done in a voluntary, intelligent, and knowing manner.[250] The circumstances of a waiver could, however, involve an "adhesion contract" in which case a waiver might not be enforceable.[251] In reviewing the facts before it, the court determined that Dillee did not suffer a great disparity in bargaining power since he received a substantial right in the contract being exclusive.[252] In return for that right, he waived his hearing rights. These circumstances led the appeals court to hold that the agreement's provisions were effective as a matter of law, and that Dillee raised no fact issues as to the validity of the waiver.[253]

On motion for rehearing with respect to third-party beneficiary rights that Dillee had previously asserted, the appeals court reiterated that the waiver of rights was effective notwithstanding whether Dillee would be entitled to any third-party rights that might accrue to him from the Joint Commission on Accreditation of Health Care Organizations standards which require due process in medical staff relations.[254]

VII. MEDICAL LIABILITY

A. INDEMNIFICATION BY STATE

In 1989 the Legislature obligated the state to provide indemnification for malpractice to doctors who devote at least ten percent of their practice to charity care.[255] The indemnification, however, is available only with respect to claims that accrue on or after the effective date of the new law: January 1, 1990.[256] In *Texas v. The Thirteenth Court of Appeals*,[257] the Texas Supreme Court held that the question of when the malpractice cause of action accrues is governed by the Medical Liability and Insurance Improvement Act.[258] The Act abolished the discovery rule for "health care liability claims" in favor of a strict, two-year limitations period, beginning with one of three times: "[1] the occurrence of the breach or tort or [2] from the date the medical or health care treatment that is the subject of the claim or [3] the hospitalization for which the claim is

248. *Id.* at 309.
249. *Id.* (citing Huffington v. Upchurch, 532 S.W.2d 576 (Tex. 1976)).
250. *Id.* (citing D. H. Overmeyer Co. v. Frick Co., 405 U.S. 174 (1972)).
251. *Id.*
252. *Id.* at 310.
253. *Id.* at 311.
254. Dillee v. Sisters of Charity of the Incarnate Word Health Care Sys., No. 14-94-00689-CV (Tex. App.—Houston [14th Dist.] Dec. 14, 1995, no writ) (not designated for publication), 1995 WL 739416.
255. *See* TEX. CIV. PRAC. & REM. CODE ANN. § 110.002 (Vernon Supp. 1997); *see also* Texas v. Pruett, 900 S.W.2d 335, 337 (Tex. 1995) (legislature's purpose was, "in part, to encourage physicians and other health care professionals to provide charity care").
256. *See* Texas v. Thirteenth Court of Appeals, 933 S.W.2d 43, 45 (Tex. 1996).
257. 933 S.W.2d 43 (Tex. 1996).
258. TEX. REV. CIV. STAT. ANN. art. 4590i (Vernon Supp. 1997).

made is completed."[259] Even if a malpractice plaintiff were to get the benefit of an extended limitations period or a later accrual date under the Texas Constitution's open-courts provision,[260] that provision is not applicable to the question of when a malpractice cause of action accrued for purposes of the charity-indemnification statute.[261] The court "recognize[d] that under this reading of [the charity indemnification statute] there may be claims that are timely brought, but for which there is no indemnity."[262] Because the state's indemnification obligation is a voluntary one, "[t]he open courts provision does not require the Legislature to authorize indemnification of claims arising before a certain date, even if the provision would allow an injured person to sue after the limitations has expired."[263]

B. WRONGFUL PREGNANCY

Actions for "wrongful pregnancy" or "wrongful conception" are finding increasing acceptance around the country, and Texas is no stranger to that trend. In *Crawford v. Kirk*,[264] the Texarkana Court of Appeals became the most recent to recognize the cause of action, joining the courts of appeals in Waco[265] and San Antonio.[266] The mother in *Crawford* sued her obstetrician when she became pregnant with twins within months of receiving a tubal ligation. The pregnancy was medically difficult, involving three hospitalizations totaling forty-seven days. Her suit alleged negligent performance of the sterilization procedure and sought damages for the medical expenses associated with the pregnancy, physical and mental pain and suffering, and the costs of raising the twins until they reach the age of majority. The court of appeals ruled that damages would be appropriate to compensate for the medical expenses associated with the pregnancy, but not pain and suffering or maintenance and support.[267] This result places Texas squarely within the majority of jurisdictions that have considered this issue, with only three jurisdictions permitting awards

259. *Id.* § 10.01.

260. TEX. CONST. art. I, § 13. This provision prohibits an otherwise-applicable limitations period from cutting off a plaintiff's common-law cause of action before the plaintiff knew or should have known the cause of action existed. *See, e.g.*, Hellman v. Mateo, 772 S.W.2d 64, 66 (Tex. 1989); Morrison v. Chan, 699 S.W.2d 205, 207 (Tex. 1985). It also has provided the basis for the Texas Supreme Court's holding that article 4590i is unconstitutional to the extent § 10.01 would cut off a minor's cause of action before the minor attained the age of majority. *See* Weiner v. Wasson, 900 S.W.2d 316 (Tex. 1995).

261. *See Thirteenth Court of Appeals*, 933 S.W.2d at 46.

262. *Id.*

263. *Id.*

264. 929 S.W.2d 633 (Tex. App.—Texarkana 1996, writ requested).

265. *See* Flax v. McNew, 896 S.W.2d 839 (Tex. App.—Waco 1995, no writ).

266. *See* Garwood v. Locke, 552 S.W.2d 892 (Tex. App.—San Antonio 1977, writ ref'd n.r.e.). *Cf.* Terrell v. Garcia, 496 S.W.2d 124 (Tex. App.—San Antonio 1973, writ ref'd n.r.e), *cert. denied*, 415 U.S. 927 (1974) (holding that certain types of damages may not be recovered in a wrongful pregnancy case, but neither approving nor disapproving the theory of recovery).

267. *Crawford*, 929 S.W.2d at 637.

for maintenance and support.[268]

VIII. PATIENTS' RIGHTS

A. ANATOMICAL GIFTS

In *Seamans v. Harris County Hospital District*,[269] the parents of a nineteen-year-old woman who died at Ben Taub Hospital donated her body to the Baylor Medical School for anatomical study. Although this donation was communicated to Baylor, the medical school never arranged for the transfer of the decedent's body. After twenty-days in the morgue, "the body was no longer in a condition suitable for medical research,"[270] and the hospital called the parents to notify them that their daughter's body was still in the morgue. Understandably shocked and distressed, the parents sued the hospital for its negligent infliction of emotional pain and distress. Summary judgment was granted on immunity grounds,[271] and the court of appeals affirmed.

The court identified two sources of immunity. As a political subdivision of the state, the Harris County Hospital District enjoys sovereign immunity except to the extent waived by the Tort Claims Act,[272] such as when "personal injury [is] caused by a condition or use of tangible personal . . . property."[273] Plaintiffs argued that this limited waiver applied to their case because the hospital's negligent acts involved the nonuse or misuse of its "gurney, morgue refrigeration units, transport vehicle, policy and procedure manual and corpse preservation property and other equipment."[274] The court held that, notwithstanding allegations of mere use or nonuse, plaintiffs must have summary judgment evidence that would support a finding that their injury was caused by the hospital's misuse of personal property, which was lacking in this case.[275]

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268. *See* Burke v. Rivo, 551 N.E.2d 1, 6 (Mass. 1990); Lovelace Medical Ctr. v. Mendez, 805 P.2d 603, 612 (N.M. 1991); Marciniak v. Lundborg, 450 N.W.2d 243, 248 (Wis. 1990).

269. 934 S.W.2d 393 (Tex. App.—Houston [14th Dist.] 1996, no writ).

270. *Id.* at 394.

271. Had the immunity defense not been available, it would appear that summary judgment—if not an earlier dismissal on special exceptions—would also have been appropriate on the basis of the Texas Supreme Court's opinion in Boyles v. Kerr, 855 S.W.2d 593, 594 (Tex. 1993) (no cause of action in Texas for negligent infliction of mental distress).

272. TEX. CIV. PRAC. & REM. CODE ANN. § 101.021 (Vernon Supp. 1997) provides that a governmental unit is liable for:

> (1) property damage, personal injury, and death proximately caused by the wrongful act or omission or the negligence of an employee acting within his scope of employment if:
>
> (A) the property damage, personal injury, or death arises from the operation or use of a motor-driven vehicle or motor-driven equipment; and
>
> (B) the employee would be personally liable to the claimant according to Texas law; and
>
> (2) personal injury and death so caused by a condition or use of tangible personal or real property if the governmental unit would, were it a private person, be liable to the claimant according to Texas law.

273. *Id.*

274. *Seamans*, 934 S.W.2d at 395.

275. *Id.*

Even if the Tort Claims Act had been interpreted to preclude sovereign immunity, the court held that the state's Anatomical Gift Act[276] also immunized the hospital district from liability for its negligence.[277] The Act broadly provides immunity from civil and criminal liability for anyone "who acts in good faith in accordance with this chapter . . . if the prerequisites for an anatomical gift are met."[278] Although the intended beneficiaries of this immunity provision are the body and organ donors, physicians who declare death and who harvest the donated organs, and organ procurement personnel whose requests might be upsetting to grieving relatives of the deceased, the immunity provision is arguably broad enough to include the negligent hospital (or medical school) whose failure to effectuate the gift might also cause harm.

B. PATIENT DUMPING

In *Rios v. Baptist Memorial Hospital*,[279] the San Antonio Court of Appeals took a rare look at the federal Emergency Medical Treatment and Active Labor Act (EMTALA).[280] The federal statute takes aim at the practice of "patient dumping" by requiring Medicare-certified hospitals to provide a medically appropriate screening for any patient who "comes to the [hospital's] emergency department."[281] If the patient has an emergency medical condition,[282] the statute requires that the condition be stabilized and that, with some exceptions, the patient not be transferred until the emergency medical condition has been stabilized.[283]

In *Rios* the issue was whether the patient had "come to the emergency department" so as to trigger the hospital's duty to screen for an emergency medical condition. Three days after he injured his arm on the job, Rios called his personal physician, Dr. Horn, who examined him in his private office. Although Horn found no evidence of an emergency condition, he arranged for a second opinion by Dr. Holliman at Baptist Memo-

276. TEX. HEALTH & SAFETY CODE ANN. ch. 692 (Vernon 1992 & Supp. 1997).
277. *Seamans*, 934 S.W.2d at 396.
278. TEX. HEALTH & SAFETY CODE ANN. § 692.016(a) (Vernon 1992).
279. 935 S.W.2d 799 (Tex. App.—San Antonio 1996, n.w.h.).
280. 42 U.S.C. § 1395dd (1994).
281. *Id.* § 1395dd(a).
282. The statute defines "emergency medical condition" as
(A) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in—
(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
(ii) serious impairment to bodily functions, or
(iii) serious dysfunction of any bodily organ or part; or
(B) with respect to a pregnant women [sic] who is having contractions—
(i) that there is inadequate time to effect a safe transfer to another hospital before delivery, or
(ii) that transfer may pose a threat to the health or safety of the woman or the unborn child.
Id. § 1395dd(e)(1).
283. *Id.* § 1395dd(b), (c).

rial Hospital. Dr. Holliman asked that Rios meet him at the hospital's emergency room. The patient then went to the emergency room, pausing only to ask for directions to the admitting department, apparently on the assumption that he was to be examined and admitted by Dr. Holliman. The patient alleged that he was not examined and not admitted because he had no health insurance. He then went to the downtown Baptist Medical Center, where he was admitted. Before he could be treated (some four hours after going to Baptist Memorial), an abscess ruptured in his arm. He was treated by two physicians who opined that Rios "was never in danger of losing his arm or life, and he suffered no serious impairment to his bodily functions."[284] In his action against Baptist Memorial for allegedly violating EMTALA, the district court granted summary judgment to the hospital, and the court of appeals affirmed.[285]

The court of appeals concluded that on these facts, Rios never "came to the emergency department" and therefore the hospital had no duty to screen for the existence of an emergency medical condition. This is certainly a plausible reading of the statutory language and the facts of the case. However, regulations promulgated by the U.S. Department of Health and Human Services, which were neither cited nor discussed by the court of appeals, appear to be considerably less demanding. Those regulations state that "comes to the emergency department means, with respect to an individual requesting examination or treatment, that the individual is on the hospital property."[286] While there can be no disputing that Rios was "on the hospital property," it is unclear whether Rios requested examination or treatment. Although Rios apparently never asked for examination or treatment during his brief trip through the emergency room, he stated in his affidavit in opposition to the hospital's motion for summary judgment that he requested examination and treatment in the admitting department.[287] This should have created a factual issue that would have made summary judgment inappropriate, except for the court of appeals' position that Rios' request for examination or treatment had to be directed to emergency room personnel in order to trigger the screening obligation of EMTALA. This places a higher burden on patients than do the federal EMTALA regulations, which do not appear to require patients to perform triage in their own cases. In a case such as *Rios*, where all indications (including Rios' own behavior) are that no emergency medical condition existed, no harm may mean no foul. With a more sympathetic set of facts, however, the court of appeals' approach will not well serve the interests of patients.

284. *Rios*, 935 S.W.2d at 801.
285. *Id.* at 800.
286. 42 C.F.R. § 489.24(b) (1996).
287. *Rios*, 935 S.W.2d at 803.

C. Duty to Warn

In *Garcia v. Santa Rosa Health Care Corp.*,[288] the court of appeals in Corpus Christi held that a hospital had a *Tarasoff*[289]-type duty to warn a patient's fiancee that the patient, who was a recipient of the hospital's allegedly tainted blood products, could be HIV-positive.[290]

The patient was a hemophiliac who was allegedly infected with HIV when he was transfused with blood products that the hospital later learned were tainted with the AIDS virus. Although the hospital attempted to schedule the patient for annual HIV testing, it is unclear whether the hospital actually told him he might be HIV-positive.[291] In any event, he did not get tested until after he married the plaintiff. The hospital also learned of the patient's plans to marry the plaintiff, but apparently never informed her of her fiancee's likely infection.[292] Plaintiff sued the hospital for negligent failure to notify her of her fiancee's (and then husband's) probable HIV status.[293]

The hospital defended on three grounds: that it had no tort duty to inform the plaintiff concerning her fiancee's probable infection and that principles of physician-patient privilege and the Communicable Disease Prevention and Control Act (CDPCA)[294] forbid such a disclosure. The court of appeals rejected all three defenses and reversed the trial court's grant of summary judgment.

First, the court expressly adopted the reasoning of the California Supreme Court in *Tarasoff*[295] and held that

> health-care professionals who discover some disease or medical condition which their services or products have likely caused to a particular recipient and which may endanger a readily identifiable third party, owe a duty to reasonably warn the third party to the extent that such a warning may be given without violating any duty of confidentiality to the recipient of services or products.[296]

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288. 925 S.W.2d 372 (Tex. App.—Corpus Christi 1996, writ requested).

289. *See* Tarasoff v. Regents of the Univ. of Cal., 551 P.2d 334 (Cal. 1976).

290. *Garcia*, 925 S.W.2d at 377.

291. *Id.* at 378.

292. *Id.*

293. The patient was also a plaintiff in the suit as originally filed. After commencing suit, however, he and his wife divorced, and he later died. The patient's mother, as the personal representative of his estate, voluntarily dismissed his claims. In addition, the plaintiff-appellant brought a second claim against the hospital for intentional infliction of mental distress. The hospital obtained summary judgment on that claim, and the plaintiff did not appeal. *See id.* at 376 n.1.

294. Tex. Health & Safety Code Ann. § 81.103 (Vernon 1992).

295. In *Tarasoff*, a patient repeatedly told his therapist that he wanted to kill an unnamed but readily identifiable third party. When the patient carried out his plan, the woman's parent's sued the therapist on the theory that he breached his duty to their daughter to warn her of his patient's intentions. The California Supreme Court held that therapist had a duty, based upon the special relationship that exists between the patient and his therapist, "to use reasonable care to protect the intended victim against such danger . . . ." *Tarasoff*, 551 P.2d at 340.

296. *Garcia*, 925 S.W.2d at 377.

In so holding, the court of appeals has adopted a doctrine that has not been embraced by the Texas Supreme Court. The court also expanded the doctrine beyond mental-health cases, which was the context in which *Tarasoff* arose and in which a small number of Texas courts have recognized a duty to warn third parties.[297]

The court also rejected the hospital's argument that the CDPCA negates a *Tarasoff*-type duty to warn when the risk of harm is not from a threatened violent act but from HIV infection. The Act prohibits the release of HIV test results to any person, subject to certain enumerated exceptions.[298] The court of appeals read this provision narrowly, concluding that it applies only to HIV test results, not to information about a person's probable HIV status when that is determined from non-test, environmental or situational factors.[299] Similarly, the court concluded that there is no common-law confidentiality requirement when information about a person's probable HIV status is learned outside the physician-patient relationship.

The hospital's writ of review is currently pending before the Texas Supreme Court.

IX. FEDERAL DEVELOPMENTS—FRAUD AND ABUSE

Although not a *state law* development, the district court's decision in *United States* ex rel. *Thompson v. Columbia/HCA Healthcare Corp.*[300] deserves at least brief mention. This was a *qui tam* action[301] brought by a physician against Columbia/HCA and a number of related entities in

297. *See* Limon v. Gonzaba, 940 S.W.2d 236 (Tex. App.—San Antonio 1997, writ denied) (discussing Texas cases); Kehler v. Eudaly, 933 S.W.2d 321, 329-32 (Tex. App.—Ft. Worth 1996, writ denied) (same).

298. The exceptions are:

> (1) the department [of health] under this chapter;
> (2) a local health authority if reporting is required under this chapter;
> (3) the Centers for Disease Control of the United States Public Health Service if reporting is required by federal law or regulation;
> (4) the physician or other person authorized by law who ordered the test;
> (5) a physician, nurse, or other health care personnel who have a legitimate need to know the test result in order to provide for their protection and to provide for the patient's health and welfare;
> (6) the person tested or a person legally authorized to consent to the test on the person's behalf;
> (7) the spouse of the person tested if the person tests positive for AIDS or HIV infection, antibodies to HIV, or infection with any other probable causative agent of AIDS;
> (8) a person authorized to receive test results under Article 21.31, Code of Criminal Procedure, concerning a person who is tested as required or authorized under that article; and
> (9) a person exposed to HIV infection as provided by Section 81.050.

TEX. HEALTH & SAFETY CODE ANN. § 81.103 (Vernon 1992).

299. *Garcia*, 925 S.W.2d at 376.

300. 938 F. Supp. 399 (S.D. Tex. 1996).

301. A "*qui tam* action" is brought pursuant to a statute that permits private individuals to sue for damages to vindicate the interest of some governmental body or other public institution that is entitled to share in the judgment, if any. *See* BLACK'S LAW DICTIONARY 1250 (6th ed. 1990).

which the relator Thompson alleged numerous inducements and relationships that were supposed to constitute violations of the Medicare/Medicaid illegal remuneration[302] and "Stark"[303] provisions.[304] These alleged violations in turn formed the basis for Thompson's *qui tam* action on behalf of the United States pursuant to the federal False Claims Act.[305]

Relying principally upon a 1977 Fifth Circuit decision that did not involve health providers or laws,[306] the district court ruled that an essential element of a claim under the False Claims Act is that the government suffered financial harm because of the submission of a fraudulent claim, either because it paid a claim for services or items that were not provided or because it paid more than it should have on account of the defendant's fraud.[307] Although Thompson alleged that some of the services provided by the defendants were not medically necessary, the district court dismissed those allegations because they were not pleaded with the degree of particularity[308] required by Rule 9(b) of the Federal Rules of Civil Procedure.[309] Once these allegations were stricken from the complaint, Thompson could not argue that the Medicare program paid more for the services provided by the defendants even if it were assumed, as it must be for purposes of deciding a Rule 12(b)(6) motion, that the allegations of referral fraud were true. All Thompson could argue was that, had the alleged illegal remuneration not been paid, some other providers would have billed Medicare for the same services for which the defendants in this case billed Medicare. This, concluded the district court, is not enough to state a claim under the False Claims Act in the Fifth Circuit.[310]

At least two other district courts, both in the Sixth Circuit, have reached the opposite result, holding that harm to the public fisc is not an

302. 42 U.S.C. § 1320a-7b(b) (1994). This provision, in brief, makes it a crime for any individual to pay or receive, or to offer to pay or to offer to receive, anything of value, in cash or in kind, directly or indirectly, in return for or to induce a patient referral that will result in an item or a service for which the Medicare or Medicaid program will be required to pay.

303. 42 U.S.C. § 1395nn (1994). Named for the California Congressman who was its chief supporter (Rep. Whitney "Pete" Stark), this provision prohibits a physician and members of his or her immediate family from referring patients, for the purpose of receiving certain "designated health services," to entities with which the physician has a financial relationship (either an investment interest or a compensation interest). This law also prohibits such physicians from submitting bills to the Medicare or Medicaid program in connection with any such referrals.

304. Relator Thompson also alleged that the defendants filed cost reports that falsely certified the defendants' compliance with Medicare anti-fraud laws and that some of the services for which Medicare was billed were not medically necessary. *Thompson*, 938 F. Supp. at 401-02. These allegations, like the alleged violations of the referral provisions, formed the basis for Thompson's causes of action under the False Claims Act, and—like the referral claims—were dismissed by the District Court.

305. 31 U.S.C. §§ 3729 et seq. (1994).

306. United States *ex rel.* Weinberger v. Equifax, Inc., 557 F.2d 456 (5th Cir. 1977), *cert. denied*, 434 U.S. 1035 (1978).

307. *Thompson*, 938 F. Supp. at 405.

308. *Id.* at 407.

309. FED. R. CIV. P. 9(b) ("In all averments of fraud or mistake, the circumstances constituting fraud or mistake shall be stated with particularity.").

310. *Thompson*, 938 F. Supp. at 405.

essential element of a claim under the False Claims Act and that a violation of the Medicare referral provisions alone can provide the predicate for a violation of the False Claims Act.[311] The Supreme Court may shed some light on this disagreement when it decides *Hughes Aircraft Co. v. United States* ex rel. *Schumer*[312] during its 1996 Term. Among the many issues raised by this defense-contract case, Hughes Aircraft has argued there can be no liability under the False Claims Act unless the defendant's conduct has produced harm to the federal treasury.[313]

311. *See* United States *ex rel.* Pogue v. American Healthcorp, Inc., 914 F. Supp. 1507, 1513 (M.D. Tenn. 1996); United States *ex rel.* Roy v. Anthony, 914 F. Supp. 1504, 1506 (S.D. Ohio 1994).

312. No. 95-1340 (U.S.), *argued* Feb. 27, 1997, 65 U.S.L.W. 3610 (Mar. 11, 1997).

313. *Id.*