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HEALTH CARE LAW

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I. INTRODUCTION

A previous Texas Survey article categorized Texas's health care laws as "adding to the patchwork of new legal considerations that the health care industry must track and manage."[1] The cases decided during this Survey period do nothing to contradict that categorization in that they address a variety of legal issues. However, 2010 is

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1. Tara Kepler et al., *Health Care Law*, 62 SMU L. REV. 1245, 1246 (2009).

particularly noteworthy with respect to health care laws because of the Patient Protection and Affordable Care Act of 2010 ("PPACA"), which is arguably one of the most important laws affecting health care providers passed in recent years.[2] Although the fate of PPACA is unclear as of this date, the mere fact of its passage and the implementation of a number of its provisions certainly suggests that the United States may be ready to begin developing a coordinated health care program, which will undoubtedly require a response by the Texas Legislature.

Texas health care providers are affected both directly and indirectly by changes in federal health care laws. They are affected directly because many federal laws expressly determine how Texas health care providers and suppliers conduct their business and are paid for services.[3] They are indirectly affected because Texas laws often mirror their federal counterparts.[4] PPACA has already had and, in the event it is fully implemented, will continue to have an impact on the manner in which health care providers, legislators, and even the courts respond to, implement, and interpret the myriad of Texas laws that affect health care providers.[5]

II. COMPETITION, RESTRAINT OF TRADE, AND OTHER BUSINESS RESTRICTIONS

This section reviews cases that limit, restrict, or protect a health care provider's right to conduct business. In the event the federal government continues to develop initiatives such as the accountable care organization and the medical home, then some, if not all of these laws, are likely to affect how Texas health care providers participate in such initiatives.

A. Noncompetes Applied to Ownership Interests of Physicians in Surgical Centers

Texas takes the position that restraints on business do little to encourage a healthy business climate and, as such, sets specific requirements that must be met for a covenant not to compete to be enforceable.[6] Section 15.50(b) of the Texas Business and Commerce Code establishes additional elements that must be in place for a covenant not to compete to be enforceable against a physician, including a requirement that any

2. *See About the Affordable Care Act*, HEALTH.GOV, http://www.healthcare.gov/law/about/index.html (last visited May 17, 2011).

3. *See, e.g.*, 42 U.S.C. § 1395nn (2006) (restricting how and under what circumstances physicians can refer Medicare patients to entities with which the physician has a financial relationship).

4. *See, e.g.*, *Id.* § 1320a-7b(b) (the federal anti-kickback law); TEX. OCC. CODE ANN. §§ 102.001-.054 (West 2011) (the state counterpart to 42 U.S.C. § 1320a-7b(b).

5. *See supra* note 2.

6. *See* TEX. BUS. & COM. CODE ANN. § 15.50 (West 2011) ("[A] covenant not to compete is enforceable if it is ancillary to or part of an otherwise enforceable agreement at the time the agreement is made to the extent that it contains limitations as to time, geographical area, and scope of activity to be restrained that are reasonable and do not impose a greater restraint than is necessary to protect the goodwill or other business interest of the promisee.").

covenant not to compete applied against a physician includes a buyout provision.[7] *Greenville Surgery Center, Ltd. v. Beebe* tests the applicability of this rule to physicians who purchase ownership interests in an outpatient surgical center.[8]

Greenville Surgery Center (Center) was an outpatient surgical center specializing in ophthalmic surgeries. The Center was formed as a limited partnership with seventeen physician limited partners.[9] The partnership agreement included a noncompete provision that prohibited the limited partners (or certain family members) from owning an interest in, managing, leasing, or otherwise having a financial interest in a competing facility within a ten-mile radius of the Center. The agreement did not include a provision permitting the physicians to buyout the noncompete.[10]

Nine of the Center's physician owners decided to develop a new facility located 1.5 miles from the Center. The physicians intended to maintain their ownership interest in the Center while the new facility was developed. The Center requested an ownership interest in the new facility, but when refused, it informed the physicians that they were in violation of the partnership agreement's covenant not to compete.[11] The doctors filed a declaratory action to have the covenant declared unenforceable. Eventually, both parties filed motions for summary judgment, with the trial court granting the physicians' motion. The Center appealed on the breach of contract claim and took the position that section 15.50(b)(2) did not apply to this noncompete because the restriction did not limit the physicians' ability to practice medicine.[12]

The key factor in deciding this case was the Dallas Court of Appeal's finding that the section 15.50(b)(2) buyout requirement was not limited to situations in which the parties enforcing the noncompete wished to limit a physician's practice of medicine.[13] The court of appeals declined to narrowly interpret the language of section 15.50(b)(2) as applying only to physicians' practice of medicine and, as such, found that the covenant not to compete was unenforceable because it did not include a buyout provision.[14]

This conclusion is not surprising given the plain language of the statute, but it also illustrates a relatively new application of physician noncompetes that indirectly involve a physician's practice of medicine. It is not

7. *Id.* at § 15.50(b) (requiring any covenant not to compete applicable to a licensed physician to (i) allow the physician access to a list of patients he has treated within the past year, (ii) provide the physicians with access to copies of their medical records, (iii) include a buyout provision that releases the physician from the noncompete for an agreed to price, and (iv) not prohibit the physician from providing care to patients requiring continued care during the course of an illness or injury following termination).

8. Greenville Surgery Ctr., Ltd. v. Beebe, 320 S.W.3d 850, 851 (Tex. App.—Dallas 2010, no pet.).

9. *Id.* at 850.

10. *See id.* at 851.

11. *Id.*

12. *See id.* at 851–53.

13. *Id.* at 853.

14. *Id.*

unusual for health care facilities to specifically target physicians who have the ability to refer patients to their facilities when seeking out investors.[15] This practice is most frequently seen in hospitals and surgical centers, such as the one described in *Greenville*, where the physicians are permitted by the federal Stark law to refer patients to facilities in which they hold an ownership interest.[16] It is specifically because these physician owners have the ability to refer patients to the hospital or surgical center that these facilities seek out physician investors. The physicians' ability to contribute capital to the business venture is often a secondary reason for seeking their investment.[17]

In an effort to encourage these owner physicians to refer most, if not all, of their patients to the facility in which they hold an ownership interest, the operators of these facilities frequently include noncompete covenants in the partnership or subscriber agreements that prohibit owner physicians from holding an ownership interest in a facility located within the facility's geographic catchment area.[18] As illustrated by *Greenville*, such noncompetes are not enforceable unless they include all the requirements set forth in section 15.50(b).[19]

B. Antitrust to Remedy Peer Review and Credentialing Disputes

Marlin v. Robertson is a creative case that overlays the more typical medical staff credentialing or peer review dispute with allegations that three hospitals unlawfully worked together to drive two neurosurgeons out of the area.[20] In *Marlin*, the physicians blamed their failure to secure privileges at two hospitals not on the medical staff's denial of due process, but instead on a conspiracy engaged in by three area hospitals to force them out of the community. These claims, had they been true, would have required a concerted effort by three unrelated hospitals or hospital systems, working with their respective medical staffs, to drive two physicians out of the community, allegedly so that the hospitals could replace the offending physicians with others that the hospitals could better control. The San Antonio Court of Appeals rightly decided that the hospitals' actions were not a violation of the Texas Free Enterprise and Antitrust Act.[21]

Dr. Marlin and Dr. Gaskill were pediatric neurosurgeons (collectively, the Physicians) on staff at Methodist Healthcare System of San Antonio

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15. *See id.* at 850–51.
16. *See generally* 42 U.S.C. § 1395nn (2006).
17. *See Greenville*, 320 S.W.3d at 850–51.
18. *See* 42 U.S.C. § 1395nn (the federal Stark law); 42 U.S.C. § 1320a-7b(b) (the federal anti-kickback statute that, like the Stark law, strictly governs arrangements whereby physician owners are permitted to refer patients to health care facilities).
19. Tex. Bus. & Com. Code Ann. § 15.50(b) (West 2011)
20. *Marlin v. Robertson*, 307 S.W.3d 418, 423–24 (Tex. App.—San Antonio 2009, no pet.).
21. *Id.* at 431–32; *see also* Tex. Bus. & Com. Code Ann. § 15.05(b).

(MHS).[22] In 2003, the Physicians began moving their practices to North Central Baptist Hospital (North Central). Shortly thereafter, Marlin took a leave of absence from membership on the MHS medical staff, and Gaskill resigned her privileges at MHS. The Physicians had also obtained and then resigned (in 2000 and 2001, respectively) their privileges at Christus Santa Rosa Health Care (Christus), a third hospital in the area. In 2004, Marlin reapplied for privileges at MHS, and both of the Physicians reapplied for privileges at Christus. However, before either hospital finalized their applications, both of the Physicians withdrew their applications out of fear that they would be denied, which would require a report by each of the hospitals to the National Practitioners Data Bank.[23] Shortly thereafter, the Physicians closed their practices at North Central and left the area to practice in another state.[24]

Claiming violations of the Texas Free Enterprise and Antitrust Act, the Physicians eventually brought suit against all of the hospitals. They also brought a separate breach of contract claim against MHS and alleged it engaged in "malicious and sham peer review," which violated their right of due process.[25] The defendant hospitals filed for summary judgment and brought counterclaims for costs and attorney's fees. The trial court ordered the plaintiffs take nothing on their claims and denied the defendant hospitals their counterclaims. Both parties appealed.[26]

With respect to the antitrust claims, the Physicians alleged that the hospitals engaged in a concerted boycott by instructing their respective emergency department physicians to not refer to the Physicians and thereby preventing the Physicians from practicing; and by not informing patients where they could find the Physicians.[27] The Physicians also claimed that "they were driven from the 'market' by an 'improper' use of the peer review process."[28] The court of appeals analyzed the Physicians' claims under the rule of reason, in part "because courts have generally been reluctant to 'hold that a group of physicians who decide that they do not want to refer patients to a particular surgeon, . . . have committed a per se violation of the Sherman Act.'"[29]

The Physicians claimed that the hospitals benefitted economically from driving them from the market by replacing the Physicians with others they "could more easily control."[30] They also claimed that the market

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22. *Marlin*, 307 S.W.3d at 423.

23. *See generally* The Data Bank-Reporting Compliance Background, HSS.GOV, http://www.npdb-hipdb.hrsa.gov/news/reportingComplianceBackground.jsp (last visited May 10, 2011) (requiring designated health care facilities to report certain adverse actions taken against licensed physicians, including, by not limited, to denial or loss of medical staff privileges).

24. *Marlin*, 307 S.W.3d at 423.

25. *Id.* at 424.

26. *Id.*

27. *Id.* at 427–28.

28. *Id.* at 429.

29. *Id.* (quoting Pontius v. Children's Hosp., 552 F. Supp. 1352, 1370 (W.D. Pa. 1982)).

30. *Id.* at 430.

suffered from the loss of the Physicians' expertise through a decrease in quality of care and negative impact on patient care and choice.[31] The court of appeals court rejected the Physicians' arguments after finding that they offered no evidence to support their claims that the market suffered as a result of the loss of their services and that the cost of such services in the market did not increase.[32] With respect to the Physicians' claim that the other physicians in the community, through the actions of the hospitals, were trying to create a monopoly, the court of appeals concluded that none of the hospitals had the power to monopolize the market.[33]

The court of appeals also rejected the Physicians' breach of contract claim against MHS.[34] The Physicians argued that MHS breached its contractual obligation to the Physicians both when Marlin attempted to reapply for privileges and when MHS treated Gaskill inappropriately during the peer review process prior to the time she resigned from the medical staff.[35] Their argument was somewhat convoluted, but it was based on prior findings that a hospital's medical staff bylaws can create a contract between the medical staff and the member physicians—especially with respect to physician members' rights to due process in the credentialing and peer review actions of the medical staff.[36] However, in *Marlin*, the Physicians did not claim that the medical staff breached its contract with the Physicians. Instead, the Physicians claimed that MHS—through the relationship between the MHS boards, the hospital bylaws, and the medical staff bylaws—had a contractual relationship with the Physicians that was breached when the medical staff mishandled the reapplication of Marlin and Gaskill's peer review.[37] The court of appeals concluded, however, that the medical staff bylaws did not in any way define or limit MHS's power to act through its Board of Governors; therefore, "neither the Medical Staff Bylaws, nor the Credentials Manual created pursuant to those bylaws, g[a]ve rise to contractual rights."[38]

31. *Id.*

32. *Id.* at 430–31.

33. *Id.* at 431–32 (citing Spectrum Sports, Inc. v. McQuillan, 506 U.S. 447, 456 (1993)) (describing the elements a plaintiff must show to establish an attempted monopoly: (i) the defendant engaged in predatory behavior, (ii) "a specific intent to monopolize," and (iii) a "dangerous probability of achieving monopoly power").

34. *See id.* at 434–35.

35. *Id.* at 433.

36. *See id.* at 433–34 (citing Gonzalez v. San Jacinto Methodist Hosp., 880 S.W.2d 436, 439 (Tex. App.—Texarkana 1994, writ denied)).

37. *See id.* at 433.

38. *Id.* at 434 (explaining that the MHS board's authority and discretion to act on its own and to approve or decline to approve decisions of the medical staff was key to this decision).

C. Application of Peer Review Privilege

The extent of the peer review privilege[39] is periodically challenged, both to gain access to information claimed to be privileged and to protect communications between physicians related to peer review activities. *In re Higby* was a mandamus proceeding challenging the right of a physician to assert the peer review privilege with respect to communications made to a professional association grievance committee.[40] Although the decision in *In re Higby* was not particularly surprising, Justice Keyes authorized an interesting concurring opinion that chastises the majority for not addressing a "legal issue of first impression,"—whether the communications made to the professional association qualify for protection under the Texas peer review privilege.[41]

Dr. Higby and Dr. Halbridge acted as expert witnesses in the same case, one for the defense and the other for the plaintiff. Believing that Halbridge testified outside of his area of expertise and falsified statements in his expert report, Higby filed an ethics complaint with the American College of Obstetricians and Gynecologists (ACOG).[42] Halbridge then brought a defamation action against Higby, during which he sought to discover Higby's testimony to the ACOG. Higby refused to disclose his communications with ACOG, claiming they were part of a privileged medical peer review communication.[43] The trial court granted Halbridge's motion to compel Higby to answer, and Higby appealed.[44]

The issue in this case was whether communications made to the ACOG Grievance Committee were subject to the medical peer review privilege.[45] To prove his claim that the communications to the grievance committee were privileged, Higby had to show that the ACOG was a "health care entity" as defined by section 151.002 of the Texas Occupations Code, was operated under bylaws approved by the board, and was "authorized to evaluate the quality of medical and health care services or the competence of physicians."[46] Higby's proof that the ACOG was a peer review committee consisted of a copy of the ACOG's Code of Ethics and an affidavit explaining why he spoke to the committee and asserting that as a member of ACOG he had "a duty to report questionable behavior by another physician" member.[47] The Houston Fourteenth Court of Ap-

39. *See* Tex. Occ. Code Ann. §§ 160.004–.008 (West 2011) (generally protecting as privileged and confidential oral and written communications, proceedings, and records of a medical peer review committee).

40. *In re* Higby, 325 S.W.3d 740, 742 (Tex. App.—Houston [1st Dist.] 2010, no pet.).

41. *Id.* at 744 (Keyes, J., concurring).

42. *Id.* at 748–52 (Keyes, J., concurring).

43. *Id.*

44. *Id.* at 741–42.

45. *Id.* at 742.

46. *Id.* (citing Tex. Occ. Code Ann. §§ 151.002(a)(8), 151.001—165.160) (West 2004 & West Supp. 2009).

47. *Id.* at 743 (also noting that Higby referred to documents previously submitted as exhibits to his motion for summary judgment, which was orally withdrawn at the hearing on Higby's motion to compel).

peals found this evidence insufficient to show that the ACOG Grievance Committee was a medical peer review committee, and it ordered Higby to disclose his committee testimony.[48]

Justice Keyes agreed with the majority, but he provided an in-depth discussion of why the peer review privilege established by Texas Occupations Code section 151.002 does not apply to the communications provided by Higby to the ACOG, thereby providing guidance for evaluation of similar communications in the future.[49] Key factors in Justice Keyes's conclusion were that: (i) ACOG is not an organization authorized by Texas Health and Safety Code section 161.0315(a) "to form a medical peer review committee," (ii) the grievance committee was not "organized" 'to evaluate medical and health care services,'" (iii) "ACOG is not a professional society organized . . . for the purpose of evaluating a physician's provision of patient care," and (iv) Higby's grievance was not related to Halbridge's provision of care to a patient.[50] Justice Keyes arrived at this conclusion after reviewing the documentation provided by the parties describing the purpose and functions of ACOG, as well as other evidence in the record—none of which described the ACOG or its grievance committee as a medical peer review committee.[51]

III. SCOPE OF TEXAS MEDICAL LIABILITY ACT

The scope of claims eligible to fall under the scope of the Texas Medical Liability and Insurance Improvement Act, formerly Article 4590i of the Revised Civil Statutes and now re-codified in chapter 74 of the Texas Civil Practice and Remedies Code (the Medical Liability Act), is another frequently litigated issue in Texas.[52] The damage limits imposed by tort reform are almost certainly a factor in plaintiffs' efforts to restyle what may appear to be a health care liability claim into another cause of action.[53] This section of the Survey examines two cases in which Texas courts have examined the scope of the Medical Liability Act. The first case looks at a premises claim and the second attempts to reframe a health care liability claim as a breach of contract.

48. *Id.* at 743–44 (citing *Memorial Hosp.-The Woodlands v. McCown*, 927 S.W.2d 1, 11 (Tex. 1996) in which proof that a committee qualified as a medical peer review committee included affidavits of medical staff coordinators providing evidence of "the structures of hospital credentialing committees . . . including the bylaws under which such committees had been formed," was sufficient to show the committee in question was a peer review committee).

49. *Id.* at 748–52. (Keyes, J., concurring).

50. *Id.* at 751–52.

51. *Id.* at 748–51.

52. Tex. Civ. Prac. & Rem. Code Ann. § 74.001(a)(13) (West 2011) (recodifying Vernon's Ann. Civ. St. art. 4590i, § 1.03 and defining "[h]ealth care liability claim" as "a cause of action against a health care provider or physician for treatment, lack of treatment, or other claimed departure from accepted standards of medical care, or health care, or safety or professional or administrative services directly related to health care, which proximately results in injury to or death of a claimant, whether the claimant's claim or cause of action sounds in tort or contract").

53. *Id.* § 74.301 (setting a limit of $250,000 on noneconomic damages).

A. PREMISES v. HEALTH CARE LIABILITY CLAIMS

Distinguishing between health care liability claims and premises liability or other tort claims can be complex in cases involving health care facilities because the Medical Liability Act describes health care liability claims as those resulting from acts or omissions that fall outside of the standard of care for medical treatment *and* those that fall outside the standard of care related to "safety."[54] However, the Medical Liability Act does not define what constitutes a departure from the standard of care for safety, which leaves it to the courts to determine what differentiates a premises claim from a health care liability claim when patients' injuries are, at least in part, caused by a health care facility's premises, equipment, or furniture.[55]

In *Marks v. St. Luke's Episcopal Hospital*, a case the Texas Supreme Court analyzed twice, the supreme court first properly decided that injuries resulting from the failure of the footboard of a patient's bed should not be brought as a health care liability claim because the bed was not integral to the hospital's delivery of health care.[56] In its second look at the case, the supreme court changed its position and decided that the footboard *was* integral to the delivery of health care.[57] The supreme court offered little explanation for this turnaround and limited the circumstances under which patient injuries sustained in health care facilities can be brought as premises claims.[58]

Prior to *Marks*, the court adopted a rule to help distinguish medical liability claims from other types of claims.[59] In *Diversicare General Partner, Inc. v. Rubio*, the supreme court categorized what appear to be non-medical services nursing homes furnish to residents—such as supervision of daily activities, routine examinations, administration of medications, and "meeting the fundamental care needs of the residents"—as falling squarely within the scope of the Medical Liability Act, and the supreme court described medical liability claims as those in which the negligent act or omission is "an inseparable part of the rendition of medical services."[60] In *Marks*, the supreme court extended the *Diversicare* rule to the safety aspect of the Medical Liability Act and agreed with the hospital's position that the bed itself was an "inextricable part" of Marks's care and treatment.[61]

The facts of the case were relatively simple; while in the hospital, patient Marks was injured when the bed frame he was leaning on collapsed.

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54. *Id.* § 74.001(a)(13).
55. *See id.* § 74.001.
56. Marks v. St. Luke's Episcopal Hosp., 319 S.W.3d 658, 677, 685–86 (Tex. 2010) (appendix containing the supreme court's previous decision, No. 07-0783).
57. *Id.* at 666.
58. *Id.* at 664.
59. Diversicare Gen. Partner, Inc. v. Rubio, 185 S.W.3d 842, 844–45 (Tex. 2005) (analyzing a claim arising from injuries to a patient during a "sexual assault by another patient" under the theory of negligent supervision).
60. *Id.* at 849.
61. *Marks*, 319 S.W.3d at 662, 666.

Marks alleged, in relevant part, that the hospital's negligence in failing to provide him with a safe environment and in failing to properly assemble and maintain his bed contributed to his injuries.[62] The trial court found that these claims constituted a health care liability claim and required substantiation by an expert's report, which was not timely filed. The court of appeals concluded that Mark's claims were related to premises liability, not health care liability.[63] On remand from the supreme court, the court of appeals affirmed the trial court's dismissal for failure to timely file an expert's report, and the supreme court subsequently granted a rehearing.

In deciding *Marks*, the supreme court relied heavily on its previous decision in *Diversicare* and on its analysis of the Texas Legislature's intent with respect to what constitutes a departure from accepted safety standards, which it reviewed *de novo*.[64] In its review of legislative intent, the supreme court stated that the "Legislature . . . could not have intended that standards of safety encompass all negligent injuries to patients" and applied the *Diversicare* test to safety standards: the Medical Liability Act applies to injuries when "the unsafe condition or thing, causing injury to the patient, is an inseparable or integral part of the patient's care or treatment."[65]

The supreme court categorized Marks's bed as a piece of medical equipment that was specific to his care—"an integral and inseparable" part of his care. As a result, the supreme court ruled that Marks's claim was a health care liability claim and subject to the requirements and limitations of the Medical Liability Act.[66] Marks's failure to timely submit an expert report properly resulted in dismissal of his claim.[67]

This decision contravened the supreme court's first review of *Marks* in 2008, when it concluded that the assembly and maintenance of the bed did not involve the exercise of professional or medical judgment and was merely "incidental" to Marks's care and treatment.[68] In a concurring and dissenting opinion joined by Justices Gree, Guzman, and Lehrmann, Justice Jefferson took the position that a footboard on a patient's bed is no more inseparable from his care and treatment than the hospital's stairs, walls, and utilities.[69] He also pointed out that the supreme court took great pains in its first review of *Marks* to explain "why the footboard [of the bed] was *not* integral to St. Luke's delivery of health care services . . . ."[70]

62. *Id.* at 660.
63. *Id.* at 661.
64. *Id.* at 662–64.
65. *Id.* at 664.
66. *Id.* at 666.
67. *Id.* at 664–66.
68. *Id.* at 682–83 (appendix containing supreme court's previous decision, No. 07-0783).
69. *Id.* at 675 (Jefferson, C.J., concurring).
70. *Id.* (referring to the supreme court's prior decision, No. 07-0783, where the court concluded that Marks's hospital bed claim related to the failure of a piece of equipment

The supreme court's reversal in its categorization of the bed or footboard as equipment that was integral to Marks's care and treatment may be partly explained by its categorization of the bed as medical equipment. Hospital beds are classified as durable medical equipment by payors such as the Medicare program, and beds with special characteristics may be ordered by a patient's physician to meet the patient's specific medical needs.[71] In its first review of *Marks*, the supreme court provided an example of when a hospital bed might require professional judgment, such as when "a health care provider might determine that a patient's condition called for restraints and that side rails attached to the bed would suffice."[72]

If the bed in *Marks* had been ordered specifically for Marks to assist in his recovery and treatment, the supreme court's conclusion that the bed was integral to his care and treatment would have been more understandable. However, the Texas Supreme Court never referred to any special characteristics of the bed that were necessary for Marks's individual medical needs or to a health care provider's order for a specific type of bed.[73] The plurality's failure to explain the change in its categorization of the bed from incidental to Marks's care in 2008, to integral to his care and treatment in 2010, suggests that we may continue to see disputes over premises versus health care liability claims to address injuries sustained by patients in health care facilities.

B. *Breach of Contract v. Health Care Liability Claims*

Ramchandani v. Jimenez takes a different approach in trying to avoid the caps on damages for malpractice claims.[74] Patient Jimenez claimed that he and Dr. Ramchandani had a verbal agreement that only Ramchandani would perform his surgery, but Ramchandani breached that agreement when he permitted one of his associates to perform the procedure.[75] Jimenez asserted that but for this decision he would not have suffered his injuries. However, rather than bringing his claim against Ramchandani and his associate as a health care liability claim under the Medical Liability Act, Jimenez brought the claim as a breach of contract and fraud claim.[76] The trial court dismissed the majority of Jimenez's

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and that the assembly and maintenance of the bed were tasks that did not require any specialized health care knowledge and evaluation of whether they were performed negligently, so expert testimony of a medical person would not be required).

71. *See* Medicare Benefit Policy Manual ch. 15, § 110.1 (2011), *available at* https://www.cms.gov/manuals/downloads/bp102c15.pdf (establishing the definition of equipment classified by Medicare as durable medical equipment or medical equipment and stating that such equipment is generally covered by Medicare if the use is medically necessary for the specific patient's medical needs).

72. *Marks*, 319 S.W.3d at 682 (Appendix containing supreme court's previous decision, No. 07-0783).

73. *See id.* at 682–83.

74. Ramchandani v. Jimenez, 314 S.W.3d 148, 149 (Tex. App.—Houston [14th Dist.] 2010, no pet.).

75. *Id.*

76. *Id.* at 149–50.

claims for failure to file an expert witness report and denied Ramchandani's request for attorney's fees.[77]

Jimenez's injuries were unquestionably the result of his surgical procedure, and the Houston Fourteenth Court of Appeals agreed with the trial court that reframing a health care liability claim as a breach of contract case was not permissible to avoid the need to file an expert's report.[78] The court of appeals considered whether Jimenez's claims qualified as health care liability claims and whether Ramchandani was entitled to attorney's fees in accordance with chapter 74. The court of appeals concluded that the acts and omissions of Ramchandani and his associate were "an inseparable part of the rendition of health care services," thereby making Jimenez's claims health care liability claims.[79] In a footnote, however, the court of appeals left open the possibility that a breach of contract claim against a health care provider could stand alone and not be considered a health care liability claim, but it did not elaborate on the circumstance that might permit such a claim.[80]

The basis for Jimenez's breach of contract claim was that he had only consented to Ramchandani's performance of the surgery, which meant that Ramchandani's associate performed the procedure without Jimenez's consent. The Texas Supreme Court previously addressed the question of breach of contract and battery claims against a physician in *Murphy v. Russell*, in which the supreme court stated that "failure to obtain consent does not automatically result in liability" because a practitioner may have reasons to provide care without specific consent that do not breach any applicable standard of care.[81] *Murphy* was similar to *Ramchandani* in that the plaintiffs in both cases failed to file an expert's report with their pleadings. In *Murphy*, the supreme court did not permit Russell to avoid the expert report requirements of the Medical Practice Act "by filing a bare-bones pleading that assert[ed] battery based on lack of consent."[82] Thus, Jimenez's decision to file his claim as a breach of contract rather than a health care liability claim presumably was, in part, a decision related to the requirement under the Medical Liability Act for an expert report. Nonetheless, this case follows the supreme court's decision in *Murphy* that a plaintiff cannot avoid the Medical Liability Act's expert report requirement by reframing a health care liability claim as a breach of contract claim.

77. *Id.* at 151.

78. *Id.* at 150–51.

79. *Id.* at 152–53 (citing the court of appeal's finding that an anesthesiologist's breach of contract and battery resulting in injuries to a patient where in fact health care liability claims).

80. *See id.* at 153 n.3.

81. Murphy v. Russell, 167 S.W.3d 835, 838 (Tex. 2005).

82. *Id.*

IV. OTHER ASPECTS OF HEALTH CARE LIABILITY CLAIMS

A. Status of Repose

In *Methodist Health System of San Antonio v. Rankin*, the Texas Supreme Court decided that the ten-year statute of repose for medical negligence claims did not violate the Texas Constitution's open courts provision.[83] The open courts provision of the Texas Constitution provides that "[a]ll courts shall be open, and every person for an injury done him, in his lands, goods, person or reputation, shall have remedy by due course of law."[84] Section 74.251(b) of the Texas Civil Practice and Remedies Code provides that a health care liability claim must be "not later than 10 years after the date of the act or omission that gives rise to the claim."[85] Importantly, this section "is intended as a statute of repose so that all claims must be brought within 10 years or they are time barred."[86] In *Rankin*, the patient learned in July 2006 that a surgical sponge was left inside her during a November 1995 hysterectomy.[87] She sued the hospital where the operation was performed and submitted evidence that she did not know of the sponge and could not have reasonably discovered it.[88] The trial court granted the defendants' motion for summary judgment, finding that chapter 74's statute of repose barred the claim.[89] The San Antonio Court of Appeals reversed the trial court's decision and held that section 74.251(b) was unconstitutional because it restricted the patient's right to sue before she had a reasonable opportunity to discover the wrong.[90]

The Texas Supreme Court reversed the lower court's decision that section 74.251(b) contravened the open courts provision of the Texas Constitution because the statute was a "reasonable exercise of the Legislature's police power to provide a certain cutoff to claims after an ample period of ten years, . . ."[91] In making this decision, the supreme court recognized that a "few plaintiffs," like the patient who did not discover the retained sponge for eleven years, will be blocked from bringing claims through no fault of their own.[92] However, the supreme court found chapter 74's statute of repose evinced the legislature's fundamental policy choice that the collective benefits of a definitive cutoff for health care liability claims—the length of time insureds are exposed to potential liability negatively affects insurance rates—were more important than a particular plaintiff's

83. 307 S.W.3d 283, 292 (Tex. 2010).
84. Tex. Const. art. I, § 13.
85. Tex. Civ. Prac. & Rem. Code Ann. § 74.251(b) (West 2011).
86. *Id.*
87. *Rankin*, 307 S.W.3d at 285.
88. *Id.*
89. *Id.*
90. *Id.* at 290.
91. *Id.* at 285–86, 290 (relying on the test formulated in Lebohm v. City of Galveston, 275 S.W.2d 951, 955 (Tex. 1995) for whether legislative action violates the open courts provision of the Texas Constitution).
92. *Id.* at 288.

right to sue a decade after the alleged malpractice.[93]

In rejecting the lower court's rationale, the supreme court noted the important distinctions between statutes of repose and limitations. A statute of repose abrogates the discovery rule and similar exceptions to a statute of limitations.[94] In other words, if a statute of repose was subject to a plaintiff's inability to discover her injury, then it would be indistinguishable from a statute of limitations.[95] Additionally, the supreme court clarified its previous holding in *Robinson v. Weaver*, which dealt with the issue of whether a medical negligence claim based on an alleged misdiagnosis not discovered for more than two years tolled the two-year statute of limitations.[96] In deciding that a misdiagnosis claim does not trigger the discovery rule in medical negligence cases, the supreme court in *Robinson* noted that claims premised on an alleged misdiagnosis are fundamentally different than those premised on a retained foreign object.[97] Namely, the latter deserve the protection afforded by the discovery rule because the lapse of time entails neither the danger of a false or frivolous claim nor the danger of a speculative or uncertain claim.[98] In *Rankin v. Methodist Healthcare System of San Antonio, Ltd.*, the San Antonio Court of Appeals relied upon language in *Robinson* to decide that section 74.251(b) was unconstitutional.[99] However, the Texas Supreme Court noted that *Robinson* (a) dealt with a statute of limitation rather than repose, (b) did not involve a constitutional challenge, and (c) was relied upon in a subsequent case that analyzed a statute of repose under due process considerations.[100]

B. Attorney's Fees for Failure to Serve an Expert Report

In *Garcia v. Gomez*, the Texas Supreme Court considered the scope of testimony required under chapter 74 to support an award of attorney's fees for a plaintiff's failure to serve an expert report.[101] For a health care liability claim, section 74.351(b) of the Texas Civil Practice and Remedies Code provides for an award of "reasonable attorney's fees and costs of court incurred by the physician or health care provider" when an expert report is not timely served.[102] In *Garcia*, the daughter of a patient who died from a pulmonary embolism following surgery sued the treating phy-

93. *Id.*
94. *Id.* at 290.
95. *Id.*
96. 550 S.W.2d 18, 19 (Tex. 1977).
97. *Id.* at 21.
98. *Id.* at 20–21 (citing Fernandi v. Strully, 173 A.2d 277, 285 (1961)).
99. Methodist Healthcare Sys. of San Antonio, Ltd. v. Rankin, 261 S.W.3d 93, 103 (Tex. App.—San Antonio 2008), *rev'd*, 307 S.W.3d 283, 292 (Tex. 2010).
100. *Rankin*, 307 S.W.3d at 291 (referring to Trinity River Auth. v. URS Consultants, Inc.-Texas, 889 S.W.2d 259, 259 (Tex. 1994), which upheld the constitutionality of a statute of repose and discussed the foreign object and misdiagnosis distinction in *Robinson*, 550 S.W.2d at 20).
101. 319 S.W.3d 638, 643 (Tex. 2010).
102. Tex. Civ. Prac. & Rem. Code Ann. § 74.351(b) (West 2011).

sician.[103] The daughter claimed that the physician breached the standard of care by failing to install a blood filter as a preventive measure.[104] Prior to filing suit, the daughter obtained from the physician medical records that indicated the alleged breach.[105] However, post-filing, the daughter obtained from a codefendant additional records that revealed a filter was placed in her mother's chest cavity during an earlier procedure.[106] Because of this new information, the daughter filed no expert reports, and the physician moved to dismiss.[107]

The physician also moved for attorney's fees under section 74.351(b). The plaintiff opposed the fees on the basis that the physician brought the suit on himself for failing to produce medical records showing the existence of the filter.[108] The trial court granted the motion to dismiss but denied the request for attorney's fees. The physician appealed the decision, and the Corpus Christi Court of Appeals affirmed the trial court's ruling because the attorney's testimony was conclusory and failed to establish that his fees were actually "incurred."[109] In the trial court, the attorney testified that he had been "doing medical-malpractice law/litigation" since 1984 and that the reasonable and necessary attorney's fees for handling a "case like this" are $12,200.00.[110] The attorney did not testify about his hourly rate, the identity of any other attorneys who worked on the case, or specific details about the work that was done. Nevertheless, the Texas Supreme Court reversed the lower courts' decisions denying fees because "there was some evidence of these fees."[111]

The supreme court acknowledged that the physician's attorney failed to establish what fees were incurred, which was also required by the statute; however, such a failure did not preclude an award of fees.[112] In other words, even though the attorney's testimony was conclusory, this testimony satisfied the "reasonable" portion of section 74.351(b), which was enough to warrant fees. The supreme court essentially decided that the "incurred" part of section 74.351(b) could be inferred from the circumstances because "it blinks reality to assume that the attorney was a volunteer or that [the physician] did not incur attorney's fees for this work."[113] Interestingly, in making this observation, the supreme court opined that an attorney's testimony about the reasonableness of his or her fees is unlike other expert testimony.[114] It is not objectionable as conclusory because the opposing party, or the party's attorney, has knowledge of the

103. *Garcia*, 319 S.W.3d at 640.
104. *Id.*
105. *Id.*
106. *Id.*
107. *Id.*
108. *Id.* at 640–41.
109. Garcia v. Gomez, 286 S.W.3d 445, 449 (Tex. App.—Corpus Christi 2008), *rev'd on other grounds*, 319 S.W.3d 638, 643–44 (Tex. 2010).
110. *Garcia*, 319 S.W.3d at 641.
111. *Id.* at 643.
112. *Id.*
113. *Id.* at 642.
114. *Id.* at 641.

time and effort involved.[115] Accordingly, the opposing party may, and now should, question the attorney regarding the reasonableness of his fee, which the plaintiff's attorney in this instance failed to do.[116]

Chief Justice Jefferson and Justice Johnson dissented from the majority's opinion because they believed that section 74.351(b) required evidence of fees incurred.[117] Specifically, "[t]estimony that a fee is reasonable, without saying it was ever charged, is useless."[118] Justice Johnson also filed a separate dissent arguing that the majority's distinction of an attorney's testimony about his fees from other expert testimony was contrary to precedent.[119] In *Arthur Andersen & Co. v. Perry Equipment Corp.*, the Texas Supreme Court established the factors to be considered when attorney's fees are at issue.[120] Justice Johnson opined that the physician's attorney did not come close to establishing many of these factors, and his testimony consisted of nothing other than a prohibited *ipse dixit* by a credentialed witness.[121] Finally, Justice Johnson noted that the majority's holding would "require [a party opposing attorney's fees] to cross-examine an opposing party's expert and assist in proving up a case against himself or herself on pain of converting conclusory, legally insufficient evidence into legally sufficient evidence."[122]

V. TEXAS PROVIDERS CHALLENGING FEDERAL LAWS

A. Imposition of CMP for Violations of Conditions of Participation

Texas facility licensing standards often mirror the Center for Medicare and Medicaid Services (CMS) conditions of participation (CoP), and Texas licensing agencies frequently work together with CMS to monitor compliance with these standards and rules.[123] These federal and state agencies primarily enforce these rules and regulations by requiring facilities that are out of compliance to complete a plan of correction and to bring the facility back into compliance in a reasonable period of time. Failure to do so could result in fines and, in the worst cases, loss of licen-

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115. *Id.*
116. *Id.*
117. *Id.* at 644 (Jefferson, J., dissenting).
118. *Id.* at 645.
119. *Id.* at 648.
120. 945 S.W.2d 812, 818 (Tex. 1997) (establishing factors such as the time and labor required, the forfeiture of other employment, the locale's customary fee, and the results obtained).
121. *Garcia*, 319 S.W.3d at 648 (Johnson, J., dissenting) (citing Burrow v. Arce, 997 S.W.2d 229, 235 (Tex. 1999) for the proposition that "a claim will not stand or fall on the mere *ipse dixit* of a credentialed witness.").
122. *Id.* at 649.
123. Temporary Non-Agricultural Employment of H-2B Aliens in the United States, 76 Fed. Reg. 15,130, 15,159–15,160 (Mar. 18, 2011) (to be codified at 20 C.F.R. pt. 655; 29 C.F.R. pt. 503) (explaining how state agencies and CMS work together to monitor compliance).

sure or Medicare participation.[124] The federal government also has available the federal Civil Monetary Penalties Law to penalize institutional providers financially for violations of the CoP.[125]

Cedar Lake Nursing Home v. U.S. Department of Health and Human Services is an example of this type of enforcement action.[126] Cedar Lake is a nursing facility and a Medicare provider. In 2008, an elderly resident of the facility left without anyone noticing and was discovered wandering alone down a highway. The facility alarms failed to alert the operators to the resident's departure.[127] Upon investigation of the incident, CMS surveyors determined that the facility was in violation of a number of the CoP, including those requiring the facility to maintain an environment free of hazards and to adequately supervise its residents. In addition to requiring the facility correct the deficiencies, CMS imposed a financial penalty of $5,000 per incident on the facility under the Civil Monetary Penalties Law.[128]

Cedar Lake appealed CMS's decision to the Administrative Law Judge (ALJ), who rejected Cedar Lake's argument that the failure of the alarm was unforeseeable because the alarm contractor had failed to inform Cedar Hill that he disconnected the alarm. The ALJ upheld the CMP fine. The basis for Cedar Lake's appeal to the Fifth Circuit was that the ALJ made its decision on a motion for summary judgment, not an evidentiary hearing.[129] Cedar Hill requested that the matter be reviewed *de novo*.[130]

The Fifth Circuit refused to review the case *de novo* and upheld the ALJ's decision based on a previous finding that "[t]he absence of an evidentiary hearing does not alter the standard of judicial review of administrative decisions . . . because agencies have particular subject-matter experience and expertise . . . ."[131] The Fifth Circuit also held that Cedar Lake's failure to maintain adequate safeguards that prevented residents from wandering outside of the facility unattended and its failure to adequately supervise residents known to be at risk for such wandering were, without question, violations of the CoP.[132]

This case is interesting because the infraction, although potentially dangerous for the residents, did not result in harm to the patient who had wandered away from the facility. This is the type of infraction frequently

124. *See* Civil Money Penalties, Assessments, and Exclusions, 42 C.F.R. pt. 402.1(e) (2011) (establishing the right to exclude providers from participation in the Medicare program).

125. *Id.* at pt. 402.1(c) (also setting forth the circumstances under which CMP may be imposed on providers).

126. 619 F.3d 453, 455 (5th Cir. 2010).

127. *Id.*

128. *Id.*

129. *Id.* at 455–56.

130. *Id.* at 456.

131. *Id.* at 457 (citing Fal-Meridian, Inc. v. U.S. Dep't. of Health & Human Servs., 604 F.3d 445 (7th Cir. 2010)).

132. *Id.*

addressed by requiring the facility to submit a plan of correction to the Department of Health and Human Services (DHHS), with monitoring by DHHS until such time as it is confident that the circumstances resulting in the infraction have been corrected. Imposition of fines and penalties under the CMP and exclusion of the provider from participation in the Medicare program are enforcement tools that have historically been used when a provider fails to correct an identified deficiency, multiple deficiencies, or a deficiency that poses a serious risk of harm to the residents. It is possible that the facility had many more deficiencies that were not noted in this case, thereby raising the risk of harm to the residents.

The March 18, 2011 edition of the *Federal Register* published an update to the process for imposition of CMP on nursing facilities mandated by PPACA.[133] The government's purpose in revising the rules is, in part, to eliminate a nursing facility's ability to defer the financial impact of a CMP penalty through the appeals process.[134] Requiring the facility to deposit the CMP amount while appealing the government's decision achieves this aim.[135]

B. Challenge to Hospice Cap

Lion Health Services, Inc. v. Sebelius presents a somewhat rare example of a provider that successfully challenged the validity of a federal law.[136] Like all hospice providers, Lion Health was subject to a "cap" on its reimbursement from Medicare.[137] After its fiscal intermediary determined that payments received for 2006 and 2007 had exceeded the cap and demanded a refund, Lion Health filed an appeal before the Provider Reimbursement Review Board (PRRB) in accordance with the administrative appeals process.[138] Lion Health argued that the intermediary's determination was invalid because the regulation used to calculate the cap was in conflict with the statute, and thereby invalid.[139] After the PRRB denied Lion Health's appeal, the hospice care provider filed an appeal with the district court.

The district court used the two-step *Chevron* analysis to determine if the regulation Lion Health challenged was invalid; this analysis required it to ask whether, when enacting 42 U.S.C.A. § 1395f(i)(2)(C), Congress directly addressed the question asked in 42 C.F.R. § 418.309(b)(1), which is "how the 'number of [M]edicare beneficiaries' in a hospice program in an accounting year should be calculated."[140] In finding that

133. Temporary Non-Agricultural Employment of H-2B Aliens in the United States, 76 Fed. Reg. 15,130, 15,158 (Mar. 18, 2011) (to be codified at 20 C.F.R. pt. 655; 29 C.F.R. pt. 503).

134. *Id.* at 15,159–15,160.

135. *Id.*

136. Lion Health Servs., Inc. v. Sebelius, 689 F. Supp. 2d 849, 858 (N.D. Tex. 2010).

137. *See* 42 U.S.C.A. § 1395f(i) (West 2011); *see* 42 C.F.R. § 418.309 (2011).

138. *Lion Health Servs.*, 689 F. Supp. 2d at 851–52.

139. *Id.* (the method of calculating the cap is very lengthy and as such, is not included).

140. *Id.* at 856 (citing Chevron U.S.A. Inc., v. Natural Res. Def. Council, Inc., 467 U.S. 837, 842–45 (1984)).

§ 1395f(i)(2)(C) clearly specified how the Medicare beneficiaries should be counted when calculating the cap, the district court was required to give deference to the statutory description when comparing it to the section 418.309(b)(1) description. Determining that the methodology for calculating the cap was distinctly different in section 418.309(b)(1), the district court ruled that the implementing regulation was unlawful and that the DHHS was enjoined from enforcing the overpayment determination against Lion Health.[141]

Not surprisingly, DHHS appealed this decision, arguing in part that the regulation did not create an injury for purposes of determining standing. Nonetheless, the Fifth Circuit upheld the trial court's decision that the regulation was unlawful and must be set aside.[142] The Fifth Circuit agreed that Lion Health had standing to bring the challenge that the regulation contradicted Congress's intent as expressed in the statute, but it determined that the district court abused its discretion when it failed to remand the recalculation of the amount owed under § 1395f(i)(2) to DHHS.[143]

C. CHALLENGE TO PATIENT PROTECTION AND AFFORDABLE CARE ACT OF 2010

This Texas Survey of health care law would not be complete without at least mentioning that Greg Abbott, the Attorney General of the State of Texas, joined thirteen other Attorneys General in challenging the constitutionality of PPACA.[144] The case has already made it through a district court in Florida and is expected to be heard by the Supreme Court. The Attorneys General assert that PPACA violates the Tenth Amendment to the Constitution by mandating that all citizens and legal residents of the United States have qualifying healthcare coverage. As mentioned in the introduction, PPACA may potentially have an enormous impact on the country's health care system, so the outcome of this case is eagerly anticipated.

VI. CONCLUSION

The cases in this year's Texas Survey have no common theme, but they each address areas of law that are frequently litigated in Texas. Common disputes include those related to business arrangements, restrictions on physicians' ability to practice medicine, and claims for redress under the Medical Liability Act. These issues are likely to continue as Texas providers attempt to adapt their practices and business arrangements to new methodologies for payment, increased competition, and new regulations, such as those contained in PPACA. Health care providers and the attor-

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141. *Id.* at 858.
142. Lion Health Servs., Inc., v. Sebelius, 635 F.3d 693, 695 (5th Cir. 2011).
143. *Id.* at 704.
144. Complaint at 4, *State v. U.S. Dep't. of Health & Human Servs.*, case 3:10-cv-0091-RV-EMT (N.D. Fla. Mar. 23, 2010).

neys who represent them will continue to face challenges as they attempt to adapt to the new business and regulatory health care environment.