Health Care Law

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I. INTRODUCTION

THE past Survey year was one of incremental change in the health-law arena. As usual in odd-numbered years, the most significant changes in law came out of the Texas legislature, although the agencies and Texas Supreme Court made their own notable contributions, particularly with respect to telemedicine, hospital districts' liability for indigent health care, and the use of physician extenders.

Brief mention should be made of changes in law that did not occur in 2009. Two competing versions of bills to amend the so-called “futility
provision” of the Texas Advance Directives Act—one to address numerous suggestions for making the law more “family-friendly” and more procedurally balanced, the other to eviscerate the futility provision altogether—both died without getting a floor vote. The result thus resembled a similar standoff in the 2007 legislative session, and there may very well be a replay, with an uncertain outcome, when the 82nd Legislature is gavelled to a close in 2011.

II. PHYSICIANS

A. SUPERVISION AND DELEGATION

Cost-conscious states and private health plans are increasingly looking to “physician extenders” to provide health care services to patients through less-expensive providers, including physician assistants and nurse practitioners. During the past year, the legislature and the Texas Health and Human Services Commission (THHSC) wrestled with some of the implications of this development, which shows no signs of slowing down.

Effective August 5, 2009, the THHSC adopted a new regulation and amended an existing regulation pertaining to “Authorized Physician Services” in connection with the state Medicaid program. The new regulation differentiates “direct supervision,” which requires the supervising physician to be in the same office, building, or facility and immediately available to help, and “personal supervision,” which requires the supervising physician’s physical presence. Also in that section, THHSC clarified “when a supervising physician may bill Medicaid for services provided by resident physicians in the context of a [graduate medical education] program and services provided by other professionals.” Specifically, the regulation clarifies that services provided by a physician assistant or advanced practice nurse are also “covered services” under the chapter. Also, “covered physician services” include services performed by the physician, medical acts delegated by the physician to persons under the physician’s supervision, and services performed by other physicians in relation to a graduate medical education program.

Senate Bill 381, effective September 1, 2009, adds to the Occupations Code section 157.101(b-1), relating to the authority of physicians to delegate to certain pharmacists the implementation and modification of a patient’s drug therapy. Physicians can delegate to pharmacists if (1) the delegation follows a diagnosis, patient assessment, and drug therapy or-

6. 34 Tex. Reg. 5059.
8. Id. § 354.1062(b), (c).
order, (2) the pharmacist practices in the hospital, hospital clinic, or institution, (3) the hospital has bylaws that allow such, (4) the pharmacist provides his or her contact information and the physician's contact information on each prescription signed by the pharmacist, and (5) the pharmacist provides the protocol to the Texas State Board of Pharmacy. The board must list on its website a list of pharmacists who are authorized to sign prescription drug orders under this section and their delegating physicians.

Senate Bill 532, effective September 1, 2009, amends Occupations Pas Code section 157.0511, regarding a physician's delegation of prescriptive authority to physician assistants (PA) or advanced practice nurses (APNs). The board must adopt rules that require a delegating physician to register the name and license number of the PA or APN to whom the physician delegates. Section 157.053(a) is amended to include in the definition of primary practice site a location where the PA or APN practices on-site with the delegating physician more than fifty percent of the time and provides health care services for established patients, charity health care services, or emergency relief services. Section 157.0541 is amended to provide that physician supervision is adequate for the section if the delegating physician is on-site with the APN or PA for ten percent of the hours of operation of the site each month, the delegating physician reviews ten percent of the medical charts for each APN and PA at the site, and the delegating physician is available for assistance or consultation. A physician may delegate to no more than four PAs or APNs. If the board determines that the types of services provided by PAs and APNs are limited in nature and duration, then the board can modify or waive (1) the limitation on the number of PAs and APNs, up to six PAs or APNs, (2) the mileage limitation, or (3) the on-site supervision requirements.

B. PHYSICIAN RANKINGS

House Bill 1888, effective September 1, 2009, adds to the Insurance Code chapter 1460, pertaining to standards required regarding certain physician rankings by health benefit plans. Under chapter 1460, a health plan issuer cannot rank physicians, sort physicians into "tiers," or publish any ranking or tiered information unless (1) the standards used are nationally recognized standards and guidelines adopted by the Insurance Commissioner, (2) the standards are disclosed to each affected physician,
and (3) each physician has an opportunity to dispute the ranking at least forty-five days before publication.\textsuperscript{19} The statute provides specific procedures which ensure due process for a physician who wishes to challenge the rankings.\textsuperscript{20} However, a physician cannot request or require patients to agree not to rank or participate in surveys regarding the physician.\textsuperscript{21} In developing the standards, the health plan issuer must ensure that physicians are actively involved in the development of standards and that the measures and methodology used in the ranking system are valid and transparent.\textsuperscript{22}

C. Physician Medical Board Profile

House Bill 732, effective September 1, 2009, adds to the Occupations Code section 154.006(k), relating to the removal of information from a physician’s medical board profile.\textsuperscript{23} The board must remove any record of formal complaint required under section 154.006(b)(15) or (i) if the complaint was dismissed five years prior as baseless, unfounded, or not supported by sufficient evidence or if no action was taken against the physician’s license.\textsuperscript{24} Also, any record of investigation of medical malpractice claims must be removed if the investigation was resolved more than five years prior and if no action was taken against the physician’s license.\textsuperscript{25}

D. Covenants Not to Compete

Section 15.50 of the Texas Business & Commerce Code narrows the terms under which a covenant not to compete will be enforceable against a physician, in contrast to the usual rule that such covenants are enforceable as long as they are not naked restraints of trade and are reasonable as to geographical scope, duration, and scope of covered activities.\textsuperscript{26} House Bill 3623, effective September 1, 2009, amends section 15.50 to clarify that a covenant not to compete must relate to the practice of medicine in order to qualify for the special limitations in section 15.50.\textsuperscript{27} Also, section 15.50(c) is added to clarify that the enforceability of a covenant not to compete “does not apply to a physician’s business ownership interest in a licensed hospital or licensed ambulatory surgical center.”\textsuperscript{28}

\textsuperscript{19} Id.
\textsuperscript{20} Id.
\textsuperscript{21} Id.
\textsuperscript{22} Id.
\textsuperscript{24} Id.
\textsuperscript{25} Id.
\textsuperscript{26} Tex. H.B. 3623, 81st Leg., R.S. (2009).
\textsuperscript{27} Id.
\textsuperscript{28} Id.
III. PATIENTS

A. CLINICAL TRIALS AND COVERAGE

Senate Bill 39, effective September 1, 2009, adds to the Insurance Code chapter 1379, regarding coverage for routine patient care costs for enrollees who participate in certain clinical trials. Section 1379.052 requires health benefit plans to provide benefits for routine patient care costs for a federally approved clinical trial “conducted in relation to the prevention, detection, or treatment of a life-threatening disease or condition.” Chapter 1379 applies only to health benefit plans that provide medical or surgical benefits incurred from a health condition, accident, or sickness. This chapter explicitly applies to the state Medicaid program and managed care organizations contracting with THHSC to provide health care services to Medicaid recipients. Under section 1379.051, the routine costs in connection with clinical trials covered by this chapter are “costs of any medically necessary health care service for which benefits are provided under a health benefit plan.” Investigational new drugs and devices, non-health-care services, and services specifically excluded from coverage are not routine costs. However, a research institution is not entitled to reimbursement for routine patient care costs in a clinical trial unless the institution agrees to accept reimbursement at the established rates as payment in full for the patient care. This new law brings Texas in line with twenty-three other states by obviating the choice faced by many patients with life-threatening illnesses who can enroll in a clinical trial that may provide the only chance for a cure but only by risking the loss of insurance coverage for routine health care expenses.

B. ADVANCE DIRECTIVES

In the first amendment to the Advance Directives Act since 2003, the legislature passed House Bill 2585, effective September 1, 2009, which allows digital or electronic signatures and witness signatures on advance directives. Section 166.011 of the Health and Safety Code allows the digital or electronic signature of an advance directive (including a directive to physicians, medical power of attorney, and out-of-hospital do-not-resuscitate (OOH-DNR) order) by a declarant, witness, or notary, as well as the revocation of a directive. Digital signature is an electronic identifier intended by the user to have the effect of a manual signature, and requirements for a digital signature are provided by section 166.011(1).

30. Id.
31. Id.
32. Id.
33. Id.
34. Id.
35. Id.
37. Id.
38. Id.
An electronic signature is a "facsimile, scan, uploaded image, computer-generated image, or other electronic representation of a manual signature" that is intended by the user to have the effect of a manual signature, and requirements for an electronic signature are provided by section 166.011(2).39

Additionally, section 166.032 provides that a declarant may sign a directive and have the signature acknowledged before a notary instead of signing before witnesses.40 Similarly, section 166.082(b) allows a declarant to sign an OOH-DNR order and have the signature acknowledged before a notary instead of signing the DNR order before witnesses.41 Finally, a medical power of attorney may be signed by the principal and the signature acknowledged by a notary without the presence of witnesses.42 If the principal is unable to physically sign the medical power of attorney, another person may sign the medical power of attorney in the principal’s presence and at the principal’s direction using a digital or electronic signature under section 166.154(c).43

C. PROTECTED PATIENT INFORMATION

House Bill 2004, effective September 1, 2009, amends Business and Commerce Code section 521.002(a)(2), regarding protection of “sensitive personal information.”44 The definition of “sensitive personal information” was amended to include identifying information relating to “[1] the physical or mental health or condition of the individual; [2] the provision of health care to the individual; or [3] payment for the provision of health care to the individual.”45 Section 2054.1125 of the Government Code was added to require that a state agency that owns or maintains data including sensitive personal information must comply with the notification requirements of Business and Commerce Code section 521.053 in the event of a breach of security.46 Local governments are subject to the same requirement pursuant to section 205.010 of the Local Government Code.47 Finally, Health and Safety Code section 181.006 was added to provide that for a non-governmental covered entity, protected health information includes any information that a person received health care from the covered entity.48 That information is not public information.49

House Bill 4029, effective September 1, 2009, amends Health and Safety Code section 241.151(2) and relates to the release of certain health

39. Id.
40. Id.
41. Id.
42. Id.
43. Id.
45. Id.
46. Id.
47. Id.
48. Id.
49. Id.
Health care information now includes payment information, and a hospital cannot release payment information without patient authorization. Also, under this section, the hospital can charge a fee for requested records provided to the patient or the patient’s legally authorized agent by digital or electronic medium.

D. PRESCRIPTIONS, DRUGS, AND TESTING

The Texas Medical Board issued an emergency amendment to its disciplinary guidelines, creating an exception to the general rule that a physician may prescribe drugs only to a patient with whom the doctor has a professional relationship. Beginning April 4, 2009, the general rule did not preclude a physician’s prescribing drugs to a partner of a patient who may have a sexually transmitted disease. Thus, the physician could prescribe drugs to a non-patient in this limited circumstance. The emergency rule was made permanent as of June 24, 2009.

House Bill 1924, effective September 1, 2009, adds to the Occupations Code section 562.1011, which permits a nurse or practitioner in a rural hospital to withdraw a drug from a hospital pharmacy if there is no hospital pharmacist on duty or the pharmacy is closed and the drugs have been ordered by a practitioner. Within seven days of such withdrawal, the hospital pharmacist must verify and review the withdrawal. Furthermore, a pharmacy technician in a rural hospital may, without direct supervision, enter medication orders into the data system, prepare, package, and label prescription drugs, fill a medication cart, distribute routine orders to patient care areas, and access and restock automated medication supply cabinets. The pharmacy technician must be registered, and a pharmacist must be accessible at all times to respond to the pharmacy technician’s questions. The pharmacist-in-charge in a rural hospital must also develop and implement policies for pharmacy operation when no pharmacist is on-site, and rural hospitals can establish standing protocols to include additional exceptions for when prospective drug use is necessary. Finally, section 568.008 permits a Class C pharmacy with an ongoing clinical pharmacy program to allow a pharmacy technician to verify another pharmacy technician’s work relating to certain tasks if the patient orders have been reviewed previously by a pharmacists.

51. Id.
52. Id.
54. 34 Tex. Reg. 2067 ("establishing a professional relationship is not required for a physician to prescribe medications for sexually transmitted diseases for partners of the physician’s established patient, if the physician determines that the patient may have been infected with a sexually transmitted disease").
55. 34 Tex. Reg. 4124.
57. Id.
58. Id.
59. Id.
60. Id.
Such peer review is to be conducted in accordance with policies adopted by the pharmacist-in-charge and rules adopted by the board.62

Senate Bill 904, effective May 26, 2009, adds Health and Safety Code section 481.074(d-1) to provide that a practitioner may give multiple prescriptions for a patient to receive up to a ninety-day supply of Schedule II controlled substances if four requirements are met.63 First, each prescription must be issued for a legitimate medical purpose.64 Second, the prescribing practitioner must provide written instructions that each prescription is to be filled at a later date.65 Third, the practitioner must conclude that providing multiple prescriptions to the patient does not create an undue risk of abuse.66 Finally, the prescriptions must comply with other state and federal laws.67

House Bill 1672, effective September 1, 2009, adds Health and Safety Code section 33.0021, relating to newborn screening.68 Section 33.0021 requires that the Texas Department of Health (the Department) include sickle-cell trait detection in the screening for heritable diseases and newborn screening.69 Section 33.0111 requires that the Department develop a statement to clearly disclose to the parent or guardian of a newborn child (1) that the Department can retain genetic material used to conduct the newborn screening test, and how the material will be used, and (2) that the parent or guardian can limit the use of genetic material by providing a written statement to such effect.70 This disclosure statement must be included on paperwork that informs the parents about the screening, must be on a separate sheet, and must be presented with a statement that allows the parent to limit the use of the genetic material.71 The physician attending the newborn must present the disclosure statement to the parents when the newborn is subjected to the screening, and the Department must develop procedures to provide verification to the Department that the parents were provided with the statement.72 Under section 33.0112, the parent or guardian may file a written statement with the Department prohibiting the retention and use of the genetic material, and the department must destroy the genetic material within sixty days of receiving the statement.73 Furthermore, all records relating to this chapter are confidential and not subject to subpoena except under limited circumstances, such as with client consent or by court order.74 However, if
the child or family is not identified, disclosure for statistical purposes or quality assurance purposes is permitted.75

House Bill 1795, effective September 1, 2009, is entitled “Greyson’s Law” and amends Health and Safety Code section 33.011(a-1), relating to newborn screening by requiring the Department of Health to add at least twenty disorders to the list of required newborn screening tests.76 Section 33.017 creates a Newborn Screening Advisory Committee, which consists of members appointed by the state health services commissioner and must include health care providers, a hospital representative, persons with family members affected by a condition for which newborn screening is required, and persons involved in the delivery of newborn services.77 Also, section 81.090 is amended to provide that a physician attending a pregnant woman must test the woman in her third trimester for HIV infection and must retain reports of each case for nine months.78 Similarly, a physician present at a delivery shall test the woman on admission for delivery for syphilis and hepatitis B, and if the physician discovers that the woman has not been tested for HIV, the physician must expeditiously test her for HIV infection.79 If a physician present at delivery does not find in the woman’s records a test for HIV infection, and such test was not performed prior to delivery, the physician should test the newborn child for HIV infection less than two hours after birth.80 However, a physician may not conduct any of the aforementioned tests if the woman or the newborn child’s parent or guardian objects to the test.81

IV. HEALTH CARE LIABILITY CLAIMS

Marks v. St. Luke’s Episcopal Hospital is one of the many medical-liability cases filed before the 2003 medical-malpractice reform statute became effective. The issue in Marks—the meaning of “health care liability claim” as found in the Medical Liability and Insurance Improvement Act (MLIIA)83—remains significant for hundreds of cases governed by the MLIIA rather than the 2003 reform statute.

In Marks, the Texas Supreme Court distinguished a premises-liability claim from a claim of medical negligence and held that only the latter was a health-care liability claim under the MLIIA. While recovering from back surgery at St. Luke’s Hospital, Irving Marks fell and injured himself

75. Id.
77. Id.
78. Id.
79. Id.
80. Id.
81. Id.
83. Id. at *1. The MLIIA, TEX. REV. CIV. STAT. ANN. art. 4950i (Vernon 1977), was repealed on September 1, 2003, and replaced by TEX. CIV. PRAC. & REM. CODE ANN. §§ 74.301–303 Marks, 2009 WL 2667801, at *1 n.2.
while attempting to stand using his hospital bed footboard. Marks sued St. Luke's for negligence, alleging failure to train and supervise staff properly, failure to provide him living assistance, failure to provide a safe environment, and providing a negligently assembled and maintained hospital bed. The trial court characterized Marks's claim as a health care liability claim under the MLIIA and granted St. Luke's motion to dismiss in light of Marks's failure to file a timely expert report as required by the statute. The court of appeals originally concluded that Marks did not assert a health care liability claim, but on remand from the Texas Supreme Court, the court of appeals affirmed the trial court decision.

The Texas Supreme Court held that Marks asserted both a health-care liability claim, which was subject to the requirements of the MLIIA, and a premises-liability claim, which was not subject to the Act's requirements. To begin its analysis, the supreme court looked to the language of the MLIIA:

The Act defines a “health 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” proximately resulting in a patient's injury or death. The Act does not define safety.

To avoid a characterization of his claim as a health care liability claim, Marks argued that “safety” should be construed to include only patient care and treatment safety. St. Luke's countered that “safety” includes any unsafe condition in a health care facility.

The supreme court then looked to the legislative intent behind the MLIIA and concluded that the legislature's primary intent was to curb the medical malpractice crisis. Since medical malpractice insurance does not typically cover premises-liability claims, the supreme court was forced to determine if Marks's claim could be distinguished from the rendition of medical services. To this end, the supreme court listed three factors it considered: “(1) whether the specialized knowledge of a medical expert may be necessary to prove the claim, (2) whether a specialized standard in the health care community applies to the alleged circumstances, and (3) whether the negligent act involves medical judgment related to the patient's care or treatment.”

84. Id. at *1
85. Id.
86. Id.
87. Id. at *1-2.
88. Id. at *10.
89. Id. at *2 (quoting Tex. Rev. Civ. Stat. Ann. art. 4950i (Vernon 1977)).
90. Id. at *3.
91. Id.
92. Id.
93. Id. at *4.
94. Id.
The supreme court first examined Marks’s claims of negligent patient supervision and staff training. Finding these claims similar to claims made by a nursing home resident, which the supreme court held to be health care liability claims in *Diversicare General Partner, Inc. v. Rubio*, the supreme court concluded that Marks’ training and supervision claims were health care liability claims under the MLIIA. As to Marks’s claim that St. Luke’s negligently assembled and maintained the hospital bed, the key question was whether the unsafe bed was separable from the rendition of medical or health care services, or alternatively, whether the assembly and maintenance of the hospital bed required medical judgment. Since there was no evidence that the bed’s assembly or maintenance required medical judgment (unlike special treatment beds or medical restraints), the supreme court held that the bed was “merely incidental to the patient’s care” and that the MLIIA was not implicated. Thus, Marks pled both a health-care liability claim under the MLIIA and an ordinary negligence claim. The supreme court affirmed in part, reversed in part, and remanded to the trial court for further proceedings.

It is difficult not to agree with the four dissenting justices that the majority’s opinion encourages artful pleading to get around the various limitations and requirements that apply to health-care liability claims under the MLIIA but not to ordinary negligence claims (such as premises liability).

In *Hernandez v. Ebrom*, the Texas Supreme Court held that a health care provider’s failure to file an interlocutory appeal challenging the adequacy of a plaintiff’s expert report does not preclude challenging the report on appeal. Doctor Hernandez of the McAllen Bone and Joint Clinic performed knee surgery on Julious Ebrom. Ebrom filed a health care liability suit for complications from the surgery against Hernandez and the Clinic. As required by the Civil Practice and Remedies Code, Ebrom timely filed an expert report, and both defendants alleged that the report was deficient and filed motions to dismiss, seeking attorney’s fees and costs. The trial court denied the motion as to Hernandez but granted it as to the clinic. Before trial, Ebrom nonsuited Hernandez, and the trial court dismissed the case. Hernandez appealed the denial of his motion to dismiss, seeking his attorney’s fees.

95. 185 S.W.3d 842 (Tex. 2005).
97. *Id.* at *5-6.
98. *Id.* at *6-7.
99. *Id.* at *10.
100. See *id.* at *15 (Johnson, J., dissenting).
101. 289 S.W.3d 316 (Tex. 2009).
102. *Id.* at 317.
103. *Id.*
104. *Id.*
105. *Id.*
106. *Id.*
107. *Id.*
108. *Id.*
court of appeals dismissed Hernandez's claim for lack of jurisdiction, because the nonsuit rendered the order denying his motion to dismiss moot. On appeal to the supreme court, Ebrom argued that because Hernandez did not pursue an interlocutory appeal challenging the adequacy of his expert report permitted by section 51.014(a)(9) of the Texas Civil Practice and Remedies Code, Hernandez waived his complaint.

The Texas Supreme Court agreed with Hernandez by holding that the legislature's authorization of an interlocutory appeal in these circumstances does not imply that the legislature required an interlocutory appeal. The supreme court reversed and remanded to the court of appeals for a determination of Hernandez's claim on the merits. Chief Justice Jefferson dissented and argued that the purpose of an interlocutory appeal in this situation is "to quickly dispense with frivolous health care litigation." Thus, if the defendant can wait to challenge the expert report until after final judgment (rather than filing an interlocutory appeal after an unsuccessful challenge of the expert report), this "injects an element of uncertainty into the case and risks turning this screening mechanism into a trump card." Thus, Chief Justice Jefferson would hold that a defendant's failure to take an interlocutory appeal after an unsuccessful challenge of a plaintiff's expert report waives the defendant's right to appeal the adequacy of the report.

In Badiga v. Lopez, another expert-report case, the Texas Supreme Court held that a health care provider may make an interlocutory appeal when a plaintiff has failed to file an expert report and the trial court both denies the health care provider's motion to dismiss and grants the plaintiff a thirty-day extension to file the report. Plaintiff Maricruz Lopez filed a health care liability claim against Dr. Murthy Badiga after a colonoscopy. The Civil Practice and Remedies Code requires plaintiffs to file an expert report within 120 days after commencing a health care liability suit, but Lopez filed none. Dr. Badiga filed a motion to dismiss, and a month later, Lopez moved for more time to file an expert report. The trial court granted the extension and did not rule on Dr. Badiga's

109. Id. The supreme court reversed the court of appeals on the mootness issue. The court of appeals had relied on two of its own previous decisions in which it found the providers' appeal to have been moot after the trial court's dismissal of the claims against them. Both cases, however, were reversed by the supreme court after the court of appeals decision in the instant case. See id.
110. Id. at 318.
111. Id. at 319.
112. Id. at 321-22.
113. Id. at 331-32.
114. Id. at 331.
115. Id. at 331-32.
117. Id. at 682.
118. Id.
119. Id.; See TEX. CIV. PRAC. & REM. CODE ANN. § 74.351(a) (Vernon 2005 & Supp. 2009).
120. Badiga, 274 S.W.3d at 682.
motion to dismiss. Lopez filed an expert report within the extended time, and Dr. Badiga filed a second motion to dismiss which incorporated his first motion and challenged the adequacy of the report. The trial court denied the motion to dismiss, and Dr. Badiga filed an interlocutory appeal. Holding that the appeal pertained to the thirty-day extension, which was not appealable, the court of appeals dismissed the interlocutory appeal for want of jurisdiction.

Texas Civil Practice and Remedies Code section 74.351(b) prescribes that if the required expert report is not timely filed, the court shall award the physician attorney’s fees and costs and dismiss the claim with prejudice. Section 74.351(c) permits the trial court to grant a thirty-day extension to allow the plaintiff to cure a report found to be deficient. Interlocutory appeal is permitted by section 51.014(a)(9) from an order that denies relief under section 74.351(b), except there is no interlocutory appeal from an order granting an extension. Thus, the Texas Supreme Court noted the distinction: “Interlocutory appeal is permitted for the denial of a motion to dismiss but not for the grant of an extension to cure a deficient report.”

Badiga presented the supreme court with a question of first impression: whether an interlocutory appeal of a denial of a doctor’s motion to dismiss is permitted when the trial court grants an extension not merely to cure the deficiencies in a filed report but to file a report in the first instance. The supreme court considered the policy behind allowing an interlocutory appeal in these circumstances, and it concluded that interlocutory appeals should be permitted when the plaintiff has utterly failed to file any report, as opposed to filing a timely but inadequate report. In the supreme court’s view, this result is a corollary of the legislative policy that forbids the trial court from denying the defendant’s motion to dismiss or granting the plaintiff an extension to file when the plaintiff has missed the 120-day deadline for filing an expert report, which the supreme court likened to a statute of limitations. Dr. Badiga properly appealed the denial of his motion to dismiss, which should be considered on the merits separate and apart from the granting of an extension. The supreme court thus reversed and remanded for the court of appeals to consider the trial court’s denial of Dr. Badiga’s motion to dismiss on

121. Id.
122. Id.
123. Id.
124. Id.
125. Id. at 683; TEX. CIV. PRAC. & REM. CODE ANN. § 74.351(b) (Vernon 2010 & Supp. 2010).
126. Badiga, 274 S.W.3d. at 683; TEX. CIV. PRAC. & REM. CODE ANN. § 74.351(c).
128. Badiga, 274 S.W.3d. at 683.
129. Id.
130. Id. at 684.
131. Id. at 683.
132. Id. at 685.
V. INDIGENT HEALTH CARE

A. HOSPITAL DISTRICT IMMUNITY

In *Harris County Hospital District v. Tomball Regional Hospital*, the Texas Supreme Court held that county hospital districts are immune from suits to recover medical expenses for services rendered to indigent patients pursuant to the Indigent Health Care and Treatment Act.135

The Tomball Hospital Authority (THA) operates Tomball Regional Hospital (the Hospital). The Hospital rendered medical services to indigent Harris County residents under the Indigent Health Care and Treatment Act and sought reimbursement from the Harris County Hospital District (the District) pursuant to the Act. The District refused to pay, and THA sued. In response, the District made a plea to the jurisdiction, asserting governmental immunity from suit. The trial court granted the plea and dismissed the case, but the court of appeals determined that section 281.056 of the Health and Safety Code, which provides that hospital district boards may “sue and be sued,” waives the District’s immunity. The Texas Supreme Court reversed.

The supreme court first noted the general rule that hospital districts have governmental immunity that may be waived only by “clear and unambiguous language.” Though section 281.056 allows hospital district boards to “be sued,” the supreme court determined that the Legislature intended to invest districts with powers and authority necessary to conduct their business. There is, however, no indication that by use of the ‘sue and be sued’ language the Legislature clearly intended to waive hospital districts’ immunity from suit.

THA argued that article 9, section 4, of the Texas constitution waives the District’s immunity from suit when it requires the District to “assume full responsibility for providing medical and hospital care to needy inhabitants of the county.” However, the supreme court held that the constitution merely imposes liability on the District; it does not detail how the hospital’s liability may be enforced (for example, by suit).

Finally, the supreme court examined other statutory provisions, like the Indigent Health Care and Treatment Act, and found no clear waiver of

133. *Id.*
134. 283 S.W.3d 838, 841 (Tex. 2009).
136. *Harris County Hosp. Dist.*, 283 S.W.3d at 841.
137. *Id.*
138. *Id.*
139. *Id.*
141. *Harris County Hosp. Dist.*, 283 S.W.3d at 842.
142. *Id.* at 843.
143. *Id.*
144. *Tex. Const.* art. IX, § 4; *Harris County Hosp. Dist.*, 283 S.W.3d at 843.
145. *Harris County Hosp. Dist.*, 283 S.W.3d at 844.
governmental immunity. Thus, the supreme court reversed and dismissed the case. Chief Justice Jefferson dissenting, arguing that the Texas constitution provided for District liability for the costs of indigent health care provided by others and that the liability must be enforced in some way. Chief Justice Jefferson concluded that the governmental immunity waiver should extend only to monetary damages; THA should be able to seek injunctive relief from the District under the Texas constitution.

It is unclear whether House Bill 2963, effective September 1, 2009, would change the outcome in cases such as this one. The law amended Health and Safety Code section 61.0045(b) to clarify that if the patient to whom services are provided is an eligible county resident, the county, hospital district, or public hospital must pay the health care provider’s claim to the extent of liability under section 61.033 or section 61.060.

B. INDIGENT HEALTH CARE AND UNDERSERVED AREAS

Senate Bill 1705, effective September 1, 2009, added section 281.0282 to the Health and Safety Code to authorize the board of the Dallas County Hospital District (the District) to hire physicians, dentists, and other health care providers in order to meet its indigent-care responsibilities through its community-oriented primary care clinics. The law provides an exception to the state’s prohibition against the corporate practice of medicine, which would otherwise prevent the District from employing the health care professionals. The board may employ health care providers for a maximum term of four years “as the board considers necessary for the efficient operation of the district.” This power extends only to the extent necessary to fulfill the District’s requirement to provide health care for indigent residents. However, consistent with the philosophy behind the corporate-practice doctrine, section 281.0282 specifically does not authorize the board to supervise or control the practice of medicine. Section 281.0282 requires the District to create a committee of at least five practicing physicians to approve policies and “ensure that a physician who is employed by the district is exercising the physician’s independent medical judgment in providing care to patients.”

146. Id. at 844-46.
147. Id. at 849.
148. Id. at 849-50 (Jefferson, J., dissenting).
149. Id. at 850-52.
150. Tex. H.B. 2963, 81st Leg., R.S. (2009). Also, sections 61.029(c) and 61.059(d) are amended to provide that a county, public hospital, or hospital district may provide eligible residents health care by purchasing health coverage or other benefits. Id.
152. Id.
153. Id.
154. Id.
155. Id.
Senate Bill 202, effective September 1, 2009, adds section 155.101 to the Texas Occupations Code and provides a provisional license to practice medicine in certain underserved areas. Under this section, the board must grant a provisional license to a physician in good standing in another state so that the physician can practice medicine in an underserved area. Among other requirements, the physician must be sponsored by a licensed physician unless it would pose a hardship to the applying physician. An underserved area is an area that has been designated by the federal government as a health-professional shortage area or by the federal or state government as a medically underserved area. A provisional license expires upon the earlier of the issuance or denial of a license or the 270th day after the issuance of the provisional license.

VI. FACILITY REGULATION

A. Infection Reporting

Senate Bill 203, effective September 1, 2009, amends Health and Safety Code section 98.103(a), (b) and (c). Under the amended section, a health care facility or a pediatric and adolescent hospital must report not only the incidence of surgical site infections but also the causative pathogen. The law also amends chapter 98 of the Health and Safety Code to expand the scope of the Advisory Panel on Health Care-Associated Infections to include “preventable adverse events.” The amendment creates a reporting requirement for preventable adverse events by each health care facility to the Department of State Health Services. Events that must be reported include: (1) a health care-associated adverse condition not covered by Medicare and (2) an event from the list of adverse events of the National Quality Forum. Further, section 98.109 is amended to protect state employees and officers from being questioned in civil, criminal, or other proceedings about the existence or contents of the information concerning health-care-associated infections and preventable adverse events. Finally, section 32.0312 as amended provides that the Texas Health and Human Services executive commissioner shall adopt rules to provide for the denial or reduction of reimbursement of medical assistance for preventable adverse events, and that the commissioner must ensure similarity with federal policies for Medicare and Medicaid.

157. Id.
158. Id.
159. Id.
160. Id.
162. Id.
163. Id.
164. Id.
165. Id.
166. Id.
B. Pain Management Clinics

Senate Bill 911, effective September 1, 2009, amends Occupations Code chapter 167, which regulates pain management clinics. Section 167.001 defines a pain management clinic as "a publicly or privately owned facility for which a majority of patients are issued on a monthly basis a prescription for opioids, benzodiazepines, barbiturates, or carisoprodol, but not including suboxone." Section 167.002 lists facilities to which chapter 167 does not apply, including medical or dental schools, hospitals, and state-operated facilities. Inspections of pain management clinics are authorized by section 167.052, and complaints regarding pain management clinics are investigated pursuant to section 167.053. Pain management clinics must be certified by the Texas Medical Board under chapter 167, while applications for certificates and the issuance and renewal of those certificates are regulated by sections 167.102 and 167.151. To be certified, a pain management clinic must be operated and owned by a medical director who is a physician practicing in Texas under an unrestricted license.

VII. Telemedicine

Under the Administrative Code, telemedicine is the "practice of health care delivery . . . by a provider who is located at a site other than the site where the patient is located, for the purposes of evaluation, diagnosis, consultation, or treatment that requires the use of advanced telecommunications technology." To comply with Senate Bills 24 and 760, the THHSC made several changes to the Medicaid telemedicine program. Sections 354.1430 (definitions), 354.1432 (benefits and limitations), and 354.1434 (requirements for telemedicine providers) were repealed, and new sections 354.1530 (definitions) and 354.1432 (benefits and limitations) were adopted. The new section 354.1430 removes limitations on the location of the distant site, expands the professionals who may be patient site presenters, and incorporates the federal definition of "un-
derserved area.” As to the services rendered via telemedicine, new section 354.1432 clarifies that consultations, office or outpatient visits, psychiatric diagnostic interviews, pharmacologic management, and psychotherapy provided via telemedicine are Medicaid-reimbursable if they are provided through “‘face-to-face’ interactive video communications with the client.”

In the same vein, the Texas Medical Board proposed amendments to 22 Texas Administrative Code sections 174.1, 174.2, and 174.6, as well as the addition of sections 174.7 and 174.8, concerning telemedicine, at the end of the Survey period. The amendments exempt special purpose telemedicine licenses for doctors who practice outside Texas and define “distant-site physician,” “patient-site location,” and “patient-site presenter” according to the THHSC definitions in 1 Texas Administrative Code section 354.1430. With regard to the two newly proposed regulations, 22 Texas Administrative Code section 174.7 requires that both the distant-site physician and the patient-site presenter maintain medical records of the telemedicine services. 22 Texas Administrative Code section 174.8 incorporates repealed section 174.4 language regarding the use of the Internet in medical practice and clarifies that “out-of-state physician[s] may provide episodic consultations” without Texas licensure. On November 27, 2009, the Board withdrew these proposed amendments and repeals.

On May 14, 2009, the THHSC adopted the repeal and replacement of 1 Texas Administrative Code section 355.7001, which addresses telemedicine services reimbursement. These changes are again in accordance with Senate Bills 24 and 760, and the purpose of the changes is to align the reimbursement provisions of section 354.1430 and following with section 355.7001 for reimbursement rates. The new section 355.7001 incorporates the same program policies as the changes to section 354.1430 and following, and section 355.7001(b) provides that patient sites will be reimbursed a facility fee instead of a professional fee.

177. *Id.* § 354.1430(9) (“An underserved area is an area that meets the current definition of a medically underserved area or medically underserved population (MUP) by the U.S. Department of Health and Human Services (DHHS).”).
178. *Id.* § 354.1432.
180. *Id.*
183. *Id.*
187. *Id.; 1 Tex. Admin. Code § 355.7001(b).*
VIII. CONCLUSION

Every two years the legislature spends six months considering hundreds upon hundreds of bills dealing with public health, health care providers of every type, patient issues, and taxation and liability rules that shape the delivery of health care services within the state of Texas. As this past Survey year illustrates, we are increasingly challenged to develop statutory responses to keep up with technological, medical, and political developments. Telemedicine, to take but one example from this past year, is a fast-moving field in which business practices change faster than many full-time legislatures can respond.

With the passage of a sweeping federal health care reform law in 2010, and the promulgation of well over 1,000 implementing regulations over the next four years, the need for speed as well as thoughtful deliberation will pose major challenges to state law-makers. Our new telemedicine rules illustrate an approach to developing timely responses to changes in federal law. Broad statutory delegations to state agencies that will then have the authority to develop regulatory responses to changes coming out of Washington may be our best hope for dealing with an increasingly complex health-law regime.