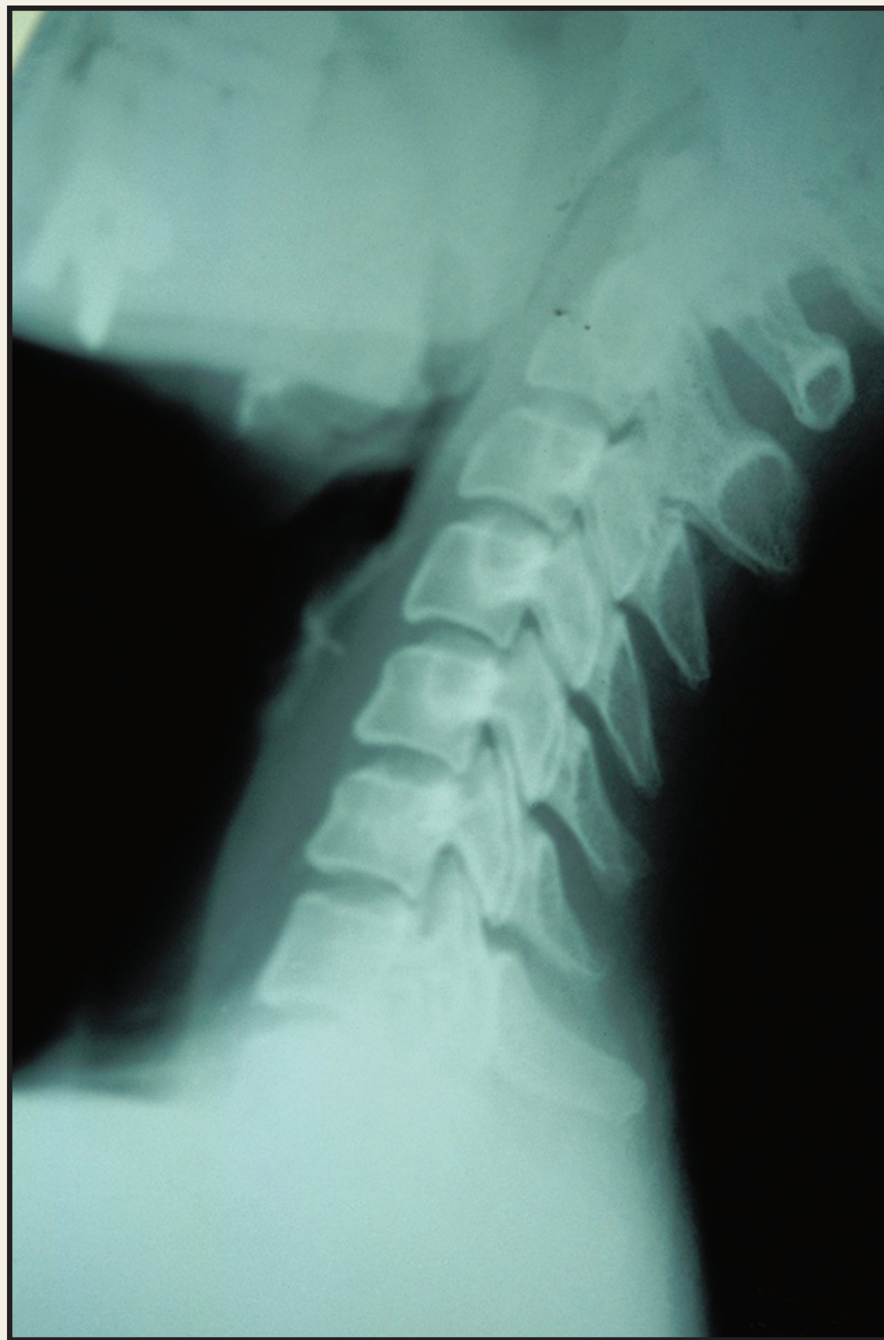
SPECIAL ADVERTISING ROUNDTABLE

Health Care Law



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Health Care Law Roundtable

THE U.S. CONTINUES TO SPEND MORE PER CAPITA THAN ANY OTHER COUNTRY ON HEALTH CARE COSTS. AND THOSE COSTS CONTINUE TO RISE. STUDIES SHOW THAT AMERICANS ARE USING MORE ELEMENTS OF PREVENTIVE OR EARLY DETECTION HEALTH CARE AND ADMISSIONS TO HOSPITALS AND THE LENGTH OF STAY AT HOSPITALS CONTINUE TO DECLINE. BECAUSE OF THIS, HOSPITAL INPATIENT CARE IS BECOMING MORE INTENSIVE AND COMPLEX AND THAT BRINGS WITH IT A WHOLE HOST OF LEGAL ISSUES. WITH ALL OF THESE ISSUES AND MANY MORE AT THE FOREFRONT, TEXAS LAWYER'S BUSINESS DEPARTMENT HAS ASSEMBLED FOUR HEALTH CARE LAW EXPERTS TO HELP UNDERSTAND THIS CHANGING LANDSCAPE. THE FOLLOWING DISCUSSION HAS BEEN EDITED FOR LENGTH AND STYLE.

MIKE ANDROVETT, moderator, attorney, journalist and owner of Androvett Legal Media & Marketing, Dallas: . . . I'm going to ask the members of the panel, in just a moment, to introduce themselves to you. What I've asked them to do is not only tell you who they are and where they work, but to describe to you with some level of intimacy the nature of their work, the sort of things they encounter on a daily basis, the sort of issues that are keeping their clients up to date and often up at night. . . . And so, with that as our overlay, I'd ask the members of the panel to introduce yourself and tell us a little bit about the nature of your practice.

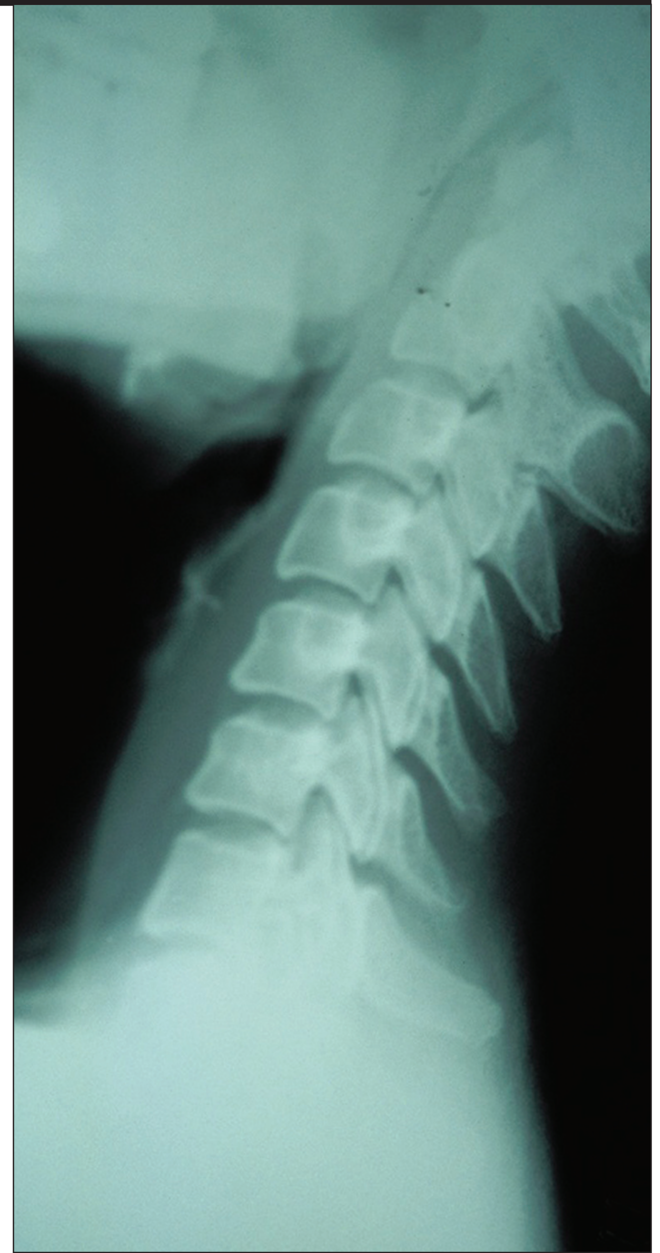
MARY–OLGA LOVETT, shareholder, Greenberg Traurig, LLP, Houston: I do commercial litigation, much of which is devoted to health care. Also, [I] concentrate on appellate practices, which touches on health care more often than not. We also, in our day-to-day practice, advise investors on health opportunities, both in Texas and nationwide. I give regulatory advice to clients who are dealing with issues in Texas, and also, with the help of my partners firm-wide, in other states. And finally, we maintain a governmental affairs practice that's active in health law, both in the state and other levels.

SUSAN I. NELSON, deputy managing shareholder, Stinnett Thiebaud & Remington LLP, Dallas: My practice is devoted to medical malpractice defense; and more specifically now, to administrative law. I'm chair of the administrative law section at our firm. That includes representing physicians, nurses, nurse practitioners, physician assistants [and] dentists before their respective licensing boards down in Austin.

KATHY L. POPPITT, partner, Thompson & Knight LLP, Austin: I am a partner in the health care section, and I represent all types of health care providers: Hospitals, nursing homes, ambulatory surgical centers, you name it in both the day-to-day operational issues that come up with transactions, relationships, joint ventures, and in the regulatory issues that come up with the enforcement agencies, such as appeals of licensure actions [and] administrative penalties. I'm currently working on a defense of a fraud abuse case. Also, [I am] representing a hospital in a dispute with a nursing home on who should have billed something, and that's in district court. . . .

BARRETT RICHARDS, partner, Stinnett Thiebaud & Remington LLP, Dallas: My practice is directed towards the business of health care providers. It involves everything from contracts to creation of entities to establishment of things like ambulatory surgery centers or 501(a) organizations which employ doctors in the State of Texas. I do a lot of work with regulatory overlay on business law because of the complexity of the regulations with health care providers. I also advise those providers with respect to taxation, both federal and state, of their entities and their interest enterprises, and help physicians and senior members of health care entities with asset protection and estate planning.

ANDROVETT: . . . If we do our job today, we'll have a chance to identify some of the key health law issues that we should all know about, maybe identify some trends for the future, and also provide some day-to-day practice advice on some of the key issues that arise. As a logical starting point, it seems like a natural question might be: In light of tort reform, what is the state of health care litigation, medical malpractice litigation?



NELSON: . . . I think what we've seen as a result of tort reform . . . [is] in some degree a reduction in the number of the lawsuits that are filed, certainly with respect to civil litigation, but what I think we found is that it's not an easy solution, necessarily. We've seen that other areas of issues involving health care providers have, in fact, increased. I think the other folks are going to talk about [the impact it has had] with respect to regulations or regulatory issues, but from my perspective we've seen a drastic increase in the number of grievances that have been filed before the Texas Medical Board, Texas Board of Nurse Examiners, and [the] Board of Dental Examiners. I think a lot of times attorneys who previously may have taken a case may feel that for . . . merit or for financial reasons, it may not be a case that they want to take, where they might have prior to tort reform. So they may be recommending to their prospective clients some attempted redress through . . . filing a complaint with the Texas Medical Board. Another reason I think we're seeing a rise in complaints or actions with health care providers is that as a result of tort reform the boards are better funded. Senate Bill 104 provided for stricter statutes [and] increased funding for the entities down in Austin; so they have hired more attorneys, more investigators [and] more compliance officers.

MARY-OLGA LOVETT is a shareholder in Greenberg Traurig, LLP and concentrates her litigation practice in health care, commercial and complex litigation. She is experienced in both trial and appellate law and has appeared before State and Federal Courts in all types of complex commercial and health care litigation, including contract disputes and business torts, products liability, toxic torts, physicians professional liability, hospital liability and employment disputes. In addition to her litigation practice, Lovett is a former adjunct professor at the South Texas College of Law and a regular lecturer at the University of Houston Continuing Legal Education Foundation, the South Texas College of Law Continuing Legal Education Foundation and the State Bar of Texas Professional Development Program.

They have panels of experts to review complaints, and have become much more involved in investigating and disciplining health care providers as a result of those complaints. So I think, from an administrative law perspective, that has affected physicians and health care providers in the State of Texas as a direct result of tort reform.

LOVETT: I agree. I think that it's certainly wise to state that tort reform has not been the complete panacea that a lot of health care providers anticipated. Certainly, the decrease in lawsuits is a good thing. But as we would expect, the Plaintiff's Bar has found creative ways to try and argue around the caps. . . . And now we're seeing, particularly in Texas, the indication of the practice of medicine doctorate to impute liability to companies, which, although involved perhaps [in] management services or in-practice management, are not enumerated health care providers under Chapter 74. But by alleging that they were actually undertaking the practice of medicine, via the legal vehicles by which they provide services, plaintiff's lawyers are now attempting to, in sort of a joint venture sense and also just in a vicarious liability sense, impute liability to companies who wouldn't typically be covered by caps. . . . That is an increased area of litigation that I think certainly we're going to see a lot more [of] in the appellate courts in the next few months.

> **I think that it's certainly wise to state that tort reform has not been the complete panacea that a lot of health care providers anticipated.**
> — MARY-OLGA LOVETT

POPPITT: I would also add that I think that one of the main pushes behind tort reform was to decrease both medical liability insurance and then hopefully decrease some of the cost of health care in general. And I've done sort of an informal survey of my clients, plus other health care attorneys that I know, and I would be hard-pressed to say that any of that has come to happen at this point. I think that there are now a few more insurance companies that will write policies in Texas that would not before, but I don't think that anybody is seeing a decrease in their premiums, or an overall decrease in costs, due to a reduction in negligence lawsuits.

ANDROVETT: This may transcend the legal arena, and forgive me if none of you have an answer for this, but it really does beg the question: If the medical malpractice insurance rates are not going down, what is happening? Why is that so? Because you're correct, that's what the popular media seemed to represent, that if only doctors could get out from under these burdensome lawsuits, everything would be right with the world.

LOVETT: I think you are seeing more carriers re-enter the market, which is a good thing, but that doesn't necessarily carry away the reduction. And obviously, some of the carriers who promised specific cuts are doing that. I had a client who's been insured by the same company for 26 years get a cancellation last week because he had one claim. And with the onset of tort reform, some people had six, seven [and] eight claims. So it's very interesting to see if that will be enough. The underwriting standards are going up, the premiums are going up, and that's the one thing that I've heard consistently, besides what Susan mentioned about the increased Board activity, that physicians are really having a hard time with, given how much hope they've put in it.

NELSON: Well, I do want to add that some of our clients are seeing a reduction in their malpractice premiums, so it's not across the board that they're staying the same or increasing. I think, with more carriers going back into the market, that [it] clearly will create a competitive market, and I think we will probably continue to see malpractice rates drop.

RICHARDS: That may not be the case, but it also is not even across the spectrum of providers. We've got several clients who have a very clean malpractice record and are not in malpractice intensive areas of practice, and yet their premiums continue to go up.

ANDROVETT: In light of all the publicity that surrounded tort reform, have you had physician clients come to you and say, "Hey, with the new caps, I don't really need medical malpractice insurance?" What's your advice to them? Or maybe they want to limit their coverage to a very low amount.

RICHARDS: I haven't had anybody come and say, "I don't need malpractice insurance." But I've had a lot of people say, "I don't want to pay for it." And the ones that have premium increases, especially when they don't have a lot of malpractice litigation, are looking for ways to cap their limits, as far as what they buy. And there are some ways to deal with that, so they can keep their premiums at some reasonable level, keep their policy limits at a lower level, and then isolate their assets in other kinds of vehicles, such as limited partnerships [and] limited liability companies. [They can] put the operating assets in one vehicle, building in another vehicle and lease

it back. There are even mechanisms where accounts receivable can be financed and isolated, so that if a creditor gets a claim the accounts receivables are protected. . . .

ANDROVETT: Going back to the more general point, that maybe the liability dangers are less in the courtroom but [more] in the administrative arena, what I hear you saying is [that] there are more dollars, more investigators, more lawyers [and] maybe the climate is a little hotter for physicians who are accused of some bad act. For our audience today, and then also for readers of *Texas Lawyer*, is there sort of a standard operating procedure? What you do on behalf of a physician who has had a complaint filed against them?

NELSON: The first thing I tell physicians is to call a lawyer. There is a standard sort of a process with respect to how administrative complaints are handled. It is certainly different, with different requirements, than civil litigation. You asked whether the climate is hotter. Because of the increased funding and stricter statutes, I think that it does give a lot of physicians and health care providers pause, at least when a complaint is filed. It's pretty scary to be sued, but it's frightening to have a complaint before a Board which controls your license, with the power to suspend your license, and/or probate it, and/or monitor it. The Board can also impose administrative penalties. When an initial complaint comes in, sometimes it's very benign. It's a letter from the Board just asking for records and asking for a narrative response in sort of a "if you're so inclined" [tone]. And those do need to be taken incredibly seriously. There's a deadline to comply with respect to the initial complaint or the initial letter from the Board. It's usually 15 days. If the reply isn't sent appropriately and timely, an automatic and formal investigation is opened up by the Board. There can be penalties of several thousand dollars a day for failure to comply. Dovetailed on that, if the physician doesn't respond to the narrative, a lot of times there's an additional complaint added on by the Board for failing to provide records in a timely manner. At any rate, with respect to the administrative process, once the Board receives a complaint, whether it's the Board of Nurse Examiners, Dental Examiners or Medical Board, it has a duty to investigate. That includes ordering records, talking to other health care providers, and having its experts, anonymous experts, look at the case. And that investigation takes about six months. Now, there are some disadvantages in Board actions that we can't avail ourselves of, things like discovery or taking depositions. But during this investigative period, we have the opportunity to retain experts, obtain appropriate literature, and get evidence that we feel is important to the Board to help it come to the right decision. After the investigative process, if [the Board] determines that there may be potential violations of a rule or regulation, it will have what's called an informal settlement conference; which is not informal, not a settlement, and not a conference. It's a mandatory hearing that you're not necessarily required to be at [and] that you typically don't reschedule for any reason other than death. We have at that time an opportunity to go before usually a three-member panel, one of whom is a phy-

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sician. The physician may not be in the same specialty as the physician you represent. We're entitled to put on evidence before the hearing, speak at the hearing, and make a recommendation regarding discipline at that point. If we disagree with that, the Board will appeal that to the State Office of Administrative Hearings, where the case is to go before an administrative law judge. . . .

ANDROVETT: Do physicians who receive an adverse ruling have any right of appeal at some point? Can they get into the courts?

NELSON: Sure. The Board will make what's called a "proposed agreed order" at various points. It's typically at the end of this informal settlement conference. It's sort of like a policeman handing you a parking ticket, you don't have to respond right then. We have an opportunity to accept the order [and] to attempt to modify its terms, which may be anything from a fine, to probation, to continuing education, to proctoring, or we can flat-out reject the order. Once we reject the order, then the state will usually file with the State Office of Administrative Hearings, and that's the next level. We then go to what's essentially a trial before an administrative law judge. We can put on evidence, do discovery prior to the hearing, determine who their expert is, and, in fact, get to depose that expert at trial. There is an appeal process after that to the district courts.

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> **— SUSAN I. NELSON**

POPPITT: I would also add that for those of you who may represent nursing homes, that when the state survey agencies come into a nursing home and write a deficiency for substandard quality of care, . . . that there is at that point an automatic referral of both the administrator of the nursing home and possibly the director of nurses as well, and any other nurses that were involved. . . . At that point, we generally are contacted, and my partner, Bill Hopkins, handles those kinds of things. But we tell our clients that [right] then is the absolute perfect time to start gathering your information, putting together the documents and putting together your defenses, because you know it's going to happen even before you get a formal notice. So you do have kind of a jump-start on those situations.

RICHARDS: Also, if you represent nursing home chains, the decision whether to accept or reject any sort of censure is complicated by the fact that something applied against one home will also be applicable to every home in the chain, to some extent.

ANDROVETT: Panel members, as we move away from tort reform for a second, I want to pick up a thread of something that one of you said; and that had to do with the business of health care and the business of health law. At this juncture in January of 2007, what are the pressures? What are the trends that are impacting your clients? Said another way, what is it that's keeping them up at night, when they are thinking about their business and the legal issues that might be implicated?

RICHARDS: The primary thing that is affecting most of my clients is the financial affects that all of these changes are having on their practices. At one time, the limitations imposed by federal payment programs affected everybody a little bit. It's gotten to the point where it's affecting practitioners across the board more and more; and it's climbing up the tree, so that specialists who used to be relatively immune to limitations on funding of various sources are feeling the pinch. That's only going to become more intense, I think. So one of the things that almost everyone is looking toward is some way to increase the revenue base so that they can have income from sources other than just the practice of medicine or the selling of durable medical equipment or pharmaceuticals. The concerns that exist with that, of course, are that there are severe criminal and civil penalties for undertaking different kinds of ventures that are not in strict compliance with the law. Anti-Kickback law provides up to a $25,000 fine and up to five years in prison and mandatory exclusion from the Medicare and Medicaid for each referral that's made in violation of the law. And it's technical enough that it's pretty easy to fall athwart of the law. That's one of the main things people are concerned about.

ANDROVETT: These restrictions on funding, are you talking about Medicare, Medicaid [and] private pay? All of the above?

RICHARDS: Yeah, across the board, because everything that the government does, the private sector tries to follow as quickly as possible.

POPPITT: I just read a poll yesterday, in fact, of hospital CEOs. And I work a lot with hospitals, and it was asking them this very question: What keeps them awake at night; what are their biggest concerns? And their number one

concern was the reimbursement issues. There have been tremendous changes in almost every single area of the profession in the industry over the last year in Medicare reimbursement rates, a complete overhaul of the way that hospitals are paid [and] doctors were changed. ASCs [Ambulatory Surgical Centers] have seen the same sort of changes, and everybody's still trying to figure out where that leaves them, and what we have to do as a result. The second issue that was really important to the CEOs has moved up in the criteria of importance; and that is, relationships between the physicians and the hospitals. There are a lot of tensions — mostly created because of these reimbursement issues — between the hospitals and the physicians. Physicians are, due to their own economic pressures, creating specialty hospitals, ambulatory surgical centers, diagnostic centers [and] imaging centers. [They are] investing in these and choosing to do their own thing, rather than use the hospital as much. And these are creating much more competition for the same patient numbers and even fewer dollars. So this is leading both hospitals and physicians to try to come up with interesting ways to benefit their bottom line. I think we're going to see, as attorneys for these people, more interesting joint venture proposals, more interesting ways in which hospitals and doctors can work together to decrease their costs, gain sharing ideas [and] things like that. And it's going to be up to us to really evaluate those situations for the hospitals and the physicians, to be sure that they are complying with the Anti-Kickback and Stark regulations. Because most of what would make sense . . . in any other industry in the world, as far as making sense to make more money, is probably illegal in the health care industry. And so, a lot of things that might make sense to people in any other business cannot be done. Or at least cannot be done without a lot of hurdles being jumped. So that's where I see the creation of joint ventures and creation of different kinds of things really picking up. The other side of that coin is, because of these pressures, I think we're also going to see a lot more peer review issues [and] a lot more charges of economic credentialing.

ANDROVETT: What is economic credentialing for someone who may not know?

POPPITT: It can be a lot of things. But generally, . . . in order for a physician to have privileges at their hospital, the hospital has put various parameters on what a doctor can and can't do, as far as its purest form. It's telling the doctor, if you want to have privileges at our hospital, you cannot invest in that ASC or that specialty hospital down the road. You can't be in competition with us and be a partner at the same time. It can be more subtle than that. It can be where you have to bring us a certain amount of things or you have to come into agreement for what we can provide each other. So, it's conditioning the granting of privileges on something economic, as opposed to just quality of care.

LOVETT: I think that there is tension, between being profitable, say, and also on the right regulatory type road. But especially clients that come from industries other than health care don't always want to hear that. So

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one of the things that I started adopting kind of on a daily basis is a belt and suspenders approach to a lot of the regulatory issues. For example, if you're trying to fit within the space of safe harbor, then get a time promotion study goal on it, that's the gold standard now, which you can actually attach to your agreement. So when you say, "This is the fair market value of that lease," you have something to back that up. . . . Or just to try and find ways where you don't stifle creativity, but at the same time you're constantly emphasizing to your clients that the regulatory risk is very real. As we see enforcement actions go up, the tension that came in the wake of the *Poliner* [*Poliner v. Tex. Health Sys.*, No. 3:00-CV-1007-P (N.D. Tex. Oct. 13, 2006)] case in Texas and the strained relations between physicians and hospitals just makes for more adverse litigation, where those groups, which were usually economically aligned, are now looking for "gotcha" moments to get the economic advantage.

POPPITT: The types of ideas that came up recently for me was a hospital that has me exploring ways we can legitimately and legally either encourage, or maybe even compel, the surgeons there to use certain equipment, supplies and devices in order to save costs. Short of doing an opinion letter that fits within the gain sharing parameters, isn't there something we can do that would not be illegal but would also help us save costs with respect to our physicians?

ANDROVETT: Just generally, the Stark Act, as you referred to earlier, basically [states that] a physician can't refer to an entity or another practice where he or she has a financial interest. I've heard a lot of criticism over the years [on] how that has stifled innovation and investment. Yet it seems that . . . this is the decade of the entrepreneurial physician. There seems like there's a bit of a disconnect there, which seems to lead to practitioners, such as yourselves, to figure out some balance between the evolution of the business model and staying within the Anti-Kickback and the Stark Act. What's the balance? . . .

LOVETT: A lot of times physicians have really great business sense, but regulatory schemes don't always make sense to them. . . . In fact, you kind of see [that] there's a move toward trying to find a way to say, "Now, look, I understand what your problem is; we've got 23 safe harbors we can work within." Understanding that in order to be bulletproof in the safe harbor, you've got to fit squarely within it. That doesn't mean, if you have an idea, it's, per se, illegal. It does mean, though, that we have to start doing things like seeking advisory opinions. That puts us on their radar and we don't want to be there. We don't want the first time you really evaluate this [to be] when the OIG [Office of the Inspector General of the Department of Health and Human Services] calls you and asks for more information. I think when you start trying to get your plan in place, sometimes you have to be pretty direct in saying, "Look, I know this makes no sense to you, and I know that 50 years ago your dad could be the ophthalmologist and have his own optical [store] and send all his patients there to fill his prescriptions [but] that's not always going to be something that you can replicate." They're good about listening to it; but because sometimes it flies in the face of what Kathy said is "typical good business sense," it's not always something that's well received.

> **I think a lot of people have HIPAA plans, and most people have an idea what HIPAA is; but I think, for the most part, it's caused more problems than it has really protected privacy.**
>
> **— KATHY L. POPPITT**

POPPITT: We do get guidance regularly from the CMS, the Centers for Medicare/Medicaid Services, and the OIG, on what is and what isn't appropriate. There's been a lot of it over the last year. A lot of different letters have come out and guidance has been received over what is appropriate. There are the safe harbors and the exceptions, and then there's just continuing information that comes out. So, there is the Stark law, but then there's the exceptions; and then, there [are] the various ways in which things can be set up. You just have to be careful that you follow those exceptions and that you follow the safe harbors in order to be in compliance with those laws. There are ways to do these things; it's just not necessarily the most intuitive or easiest way to do it. You just have to be sure to follow the guidance.

LOVETT: For clients that have business interests that expand across all 50 states, we also have various state regulatory agencies to deal with. Which, just like Barrett said, the states try to follow, but there are states that have very different requirements and different schemes. . . . [F]or example, . . . all of Florida is very friendly to the corporate practice of medicine. They also have restrictions on Medicaid, which the states control, that impose burdens on cli-

ents that they don't see in the other 50 states. So you're constantly hearing from your general counsel saying, "Why can't we do it this way in Tennessee and Connecticut"; and the answer is, "You just can't." Sometimes that's hard to get across.

RICHARDS: And the enforcement folks have a different attitude. We, as practitioners, try to come up with creative ways to fit within the rules or set up arrangements that do comply with the laws. . . . For a long time, the OIG handled Anti-Kickback matters, which are criminal, and CMS handled Stark matters, which were civil. There never really was much overlap or communication. It's gotten to the point where if one of them sees something that may be a problem, they're now notifying the other. They have taken to issuing . . . safe harbors for Anti-Kickback and exceptions in Stark in Tampa. The most recent one, which was in August of last year, deals with e-records, medical records, and e-prescribing. They issued the two sets of exceptions and two sets of safe harbors together in the same announcement. They're getting more sophisticated in the enforcement, as we try to get more sophisticated in the implementation. . . . I do a lot of tax work, and one of the things you do is look for loopholes and wind your way through the law. In health care [law], it is just the opposite. It's more of what we meant by the law than whether it really catches this thing specifically, and that puts a lot more at risk.

ANDROVETT: You mentioned the *Poliner* case, and that really shed a light on the peer review process. Extraordinary verdict at the time, I think it was about $366 million. Late last year, I think the trial court entered a judgment something in the neighborhood of $28 million. This was, I believe, a cardiologist who lost hospital privileges at Presbyterian. He alleged that he was not afforded due process. And actually, what he alleged was going on here was that people on the peer review committee were trying to eliminate him because he was a competitor at the hospital with one of their cronies. And it seemed, as an outsider, . . . in the fact that it was upheld with a limited award, sent shock waves through the health care industry, not only here in Texas but elsewhere. What has been the result, in the wake of *Poliner*, for those of you who represent hospitals?

POPPITT: I would say that since *Poliner* that most of the hospitals I represent have gone back and done a review of their medical staff bylaws to see what they say and be sure everybody knows what they say, and to be sure that we are following them. To the extent that they needed some tweaking, we've done the tweaking. I had one hospital that [has] totally rewritten their medical staff bylaws in order to be sure that due process is afforded. I think that *Poliner* had a lot of very fact-specific issues that led to the ruling. One of them was that through the peer review process, the hospital was allowing economic factors and competitors to make decisions, and they were not making correct decisions. I think that hospitals recognize that. If you're going to have true due process, then you cannot let people who are in economic competition with one another make decisions about each other's practices. That's

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not true good-faith peer review. Another one of the things that brought about the *Poliner* decision was the fact that the doctor on that case was not given an opportunity to have any input before decisions had already been made. And I think the hospitals recognize . . . that there are lots of informal steps that can and should be taken prior to an immediate suspension. . . . So I think that most hospitals have sort of taken stock on how to proceed with these and are double-checking to make sure that, in fact, they are providing due process.

RICHARDS: Which is beneficial, I think, across the board in some respects, although I'm sure that Presbyterian wouldn't agree with that. But the idea that there is serious risk in not following your bylaws and serious risk in not giving due process is a foolish idea to some hospital folks. We've been preaching for years that you need to follow your bylaws [and] you need to follow the Health Care Quality Improvement Act, which sets out the due process standards. And doctors, especially on the various committees, the medical executive committees, really balk at going through the formal steps. And preaching to them just doesn't do much good, unless you're in a position to insist, which sometimes is difficult. So having this kind of risk is a good thing from that standpoint. The other thing that I see is, this is a little more far reaching than just in peer review, in that hospitals I'm dealing with from the doctors' side, are much more interested in getting their contractual house in order and getting arrangements with the doctors formalized, so that they can have clear-cut guidance on what they have the right to do and what they don't.

ANDROVETT: I talked about this movement into different areas of health care. What comes to mind now is what we call the boutique hospital or the niche hospital. Can one or all of you talk a little bit about that development and what impact that has on both your practice and the evolving law in that area.

POPPITT: Well, I think that at some point the market is going to be saturated with just how many hospitals and clinics and ASCs we have. In fact, I was reading yesterday about two ASCs that had been physician-owned but now have been bought by nonprofits because there was just too much competition, and they decided they were better off together than separate. I don't know how much of an indication that is [that there is] a change in the trend or not. So I think physicians need to be mindful of just how much competition there is and whether there is additional room for another venture, and I think a market analysis will be important in any physician's hospital or surgery center that you represent. Also, I know that some of the more expensive boutique hospitals that are saying that they provide accommodations like the Four Seasons Hotels are having trouble getting onto any insurance plans. Because we have so many hospitals on already, and they are telling us, "if we put you on, they're going to pull away. And why would we want to pay your rates that are much, much higher than any of the other hospitals." . . . Overall, I think that the ventures for either smaller private hospitals or ambulatory surgical centers that happen between the hospitals and the physicians probably are going to be the bigger trend and have the better opportunities for being successful long-term.

> **A lot of physicians are beginning to look at professional limited liability companies, which have, in addition to the limited liability of the corporation, or a PA, a lot of flexibility.**
> **— BARRETT RICHARDS**

RICHARDS: I agree. The idea that economic credentialing can be a factor in hospitals dealing with doctors who have interests in specialty hospitals, ambulatory surgery centers or imaging centers is a powerful one, from the hospital standpoint, because these things really do cut into their revenue stream. So there's a lot of incentive for the hospitals to, instead of trying to shut down the doctors or exclude them, join with them, to at least get some of the benefit of the ambulatory surgery center, for example, which has substantially lower costs. It started out a few years ago that hospitals were really against the idea of these specialty providers and hospitals, because they did cut into the patient flow. And it seemed like the specialty places were getting the healthier, more well-to-do patients, and the sicker and poorer patients were winding up in the full-service hospitals. So they would push against any expansion of ambulatory surgery centers or boutique hospitals. . . . Interestingly enough, the result of all of that has been that governmental regulators as well as hospital providers are realizing that these kinds of centers do have substantially lower costs; that the providing of emergency room care and care for really sick people in the full-service hospitals requires a lot more expense. So even though they're not particularly fond of them, the government and the regulators that deal with this are leaning toward

the idea that we can save money by using these. So while there will be some sort of saturation point, there is going to be a push to use these as a mechanism to reduce costs.

POPPITT: Right. I also wonder to some extent about the change in Congress, now that we have a Democratic Congress. We didn't have a lot of support from the Republicans in continuing the development of specialty hospitals. [There was a moratorium that they chose during a time in which new specialty hospitals could not be built, and they chose not to extend that moratorium.] But I understand that possibly the new Democratic Congress is going to have a different take on that and may choose to limit that. So that will certainly be something to watch and see what happens.

ANDROVETT: How about the state legislature, any initiatives that any of you are watching in this year's session?

POPPITT: Well, they took some action on specialty hospitals last year and commissioned a study we call "Niche Hospitals in Texas," and they chose not to do anything at that time. But recommendations were made, and I think that is something we have to watch at this time to see what will happen. There are not that many states in the country that have specialty hospitals. Texas has more than any state, and Dallas has a tremendous concentration of specialty or niche hospitals. And that's because most states require a certificate of need before any health care institution can be built, and we did away with our CONs in Texas more than 20 years ago. And so, you can build a health care facility in Texas without anybody's permission. And that's unusual for the country. So Texas is in the limelight, as far as the country goes, for this issue.

ANDROVETT: Aside from the niche or boutique hospital issue, more generally, in health law, any initiatives that bears watching in the legislature?

RICHARDS: I think there's one thing that really isn't coming up in the legislature that has an affect on just about everybody in the state, including health care providers; and that is, the new Texas Margin Tax, which replaces the franchise tax. Historically, there were a lot of entities out there that could be set up to be exempt from the franchise tax. There were mechanisms where you could put a partnership in between two corporations that were located in other states and exempt your revenues from franchise tax. That got to the point where it was substantially affecting the state FISC; and as a result, they completely revamped the tax. That's going to go into effect for 2008, but it's going to be applicable to revenues that are generated in 2007. So it is something for people to watch now. It used to be that professional associations, for example, or physicians were exempt from tax. None of that is going to be available now that PAs are going to have the same tax factors as LLCs and corporations. It's going to be a much more aggressive tax, in that it's based on your gross revenues with some reductions based on cost of goods sold or some compensation limitations. Otherwise, it's a gross revenue tax, as opposed to a net profits tax.

ANDROVETT: Do you see any direct response to that tax in how health care providers either establish their new entities or how they conduct their business, or are it too early to tell?

RICHARDS: Well, it's too early to say exactly

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what's going to happen, but we're seeing a lot of interest in some different kinds of entities. For years it was kind of the common wisdom that doctors would go into PAs, either as a group or individually, because there was no franchise tax and because they were relatively simple to run. You could elect to tax them as S Corporations so that the revenues would pass through, and you really only have tax at one layer as opposed to the double corporate tax. That's all changed. Now the PAs, limited partnerships, partnerships of PAs, and partnerships of PCs are going to be subject to the tax at some level. What you look for now is not just [a] tax benefit but flexibility. A lot of physicians are beginning to look at professional limited liability companies, which have, in addition to the limited liability of the corporation, or a PA, a lot of flexibility. Unlike PAs, they can be owned by other entities. A PA has to be owned by a licensed physician or physicians. You can have a PA that owns a PLLC. You can have group PAs that own a PLLC, which is great for planning purposes. Also, if you have an individual physician who owns a PLLC, for federal tax purposes, it is treated as it doesn't exist; so there's no double taxation, and there's not a second tax return. So it's treated as if all the income were from a sole proprietor; however, you still have the asset and liability protection of a corporation.

POPPITT: The legislature almost has to amend the State Medicaid Whistle Blower statutes, because the federal government passed a law in the Deficit Reduction Act that states if you have a Medicaid Whistle Blower statute that meets our criteria and you're forcefully enforcing that, then we will allow you to keep more of your percentage of any money that is recovered in those suits. It was found that Texas' statute did not meet the criteria. . . . [T]hat decision was just made in November or December. . . . So I think the time is right for the Whistle Blower statute to be revised.

ANDROVETT: Mentioning the Deficit Reduction Act. There wasn't a lot of clamor or publicity about this, and my perception may be incorrect, so please correct me, but did the Deficit Reduction Act put a little bit more pressure on health care providers to comply with basically all things federal? Because there seemed to be a change from, "we might pull your federal reimbursement," to, "we definitely will pull your federal reimbursement if you don't comply." All that "comply" entails is a topic for another roundtable. Did the Deficit Reduction Act, without a lot of fanfare, allow for them to put more pressure on health care providers?

POPPITT: Yes, most definitely. It required CMS [The Centers for Medicaid and Medicare Services] to formulate a Medicaid integrity plan. They receive all Medicare and Medicaid in the country. Medicaid is a state program. And generally, that has been the purview of the state Medicaid agencies to enforce the rules for that. The federal government has created this Medicaid integrity plan whereby they are now taking a major role in collaborating with the states in enforcing the Medicaid anti-fraud regulations. They are going to police both providers and the states. The states now are accountable to the federal government for how they regulate the Medicaid system. And the Office of Inspector General is headed, in Texas, by a man named Brian Flood, and I've heard him speak many times on this topic in the last year. And he says, "You don't need to be afraid of me anymore, you need to be afraid of the federal government because they're coming down hard on both of us." At any one time, any one provider could be undergoing five different audits, between the state and the federal government. I think that is really going to be a big change for both the state regulators and the providers.

ANDROVETT: Panel members, acknowledging right off the bat the complexity of some of these issues and how fact based they may be, is there any guidance that you can give to us here, and then also to the readers of the *Texas Lawyer*, about the essentials of a good compliance program?

RICHARDS: Well, the compliance programs, of course, have been formulated by the government, so that there is a pro forma kind of compliance program for almost every type of provider. They started out several years ago following the guidelines that the securities laws had followed, using the federal sentencing guidelines, which gave a series of requirements for compliance going forward if someone had violated the federal law. This was adopted pretty much across the board in the health care compliance programs, so there are some specific guidelines there that are now regulatory. There also are some guidelines that deal with the internal operations. And a lot of entities will buy an off-the-shelf compliance program and implement it in a pro forma manner and then not think about it again. It's gotten to the point where if you do that, you've effectively had no compliance program, as far as the government is concerned. And if something goes wrong, you're in worse shape than if you actually didn't have a compliance program, because you've shown that you know you're supposed to and you're blatantly not dealing with it. So the creation of a culture that encourages compliance encourages the whistle blowing inside the entity is a critical requirement.

LOVETT: . . . [T]he implementation . . . has to be continuous; it has to be part of the culture. There's lots of ways to manage it. And like Barrett said, you do have off-the-shelf programs, but there are some good online tracking programs where you can track how employees are actually participating in compliance mod-

ules. You can reinforce that. Just like any policy or procedure, the policy you have and don't follow is the worst kind that you can possibly have because it opens you up to all kinds of things. And we're also seeing that companies are taking advantage of the compliance manual to also implement some things just to better their culture overall, which is a nice way to make that mandatory. But you have to have a way to track it, and you have to have a way to make sure that the culture isn't just paying lip service to the idea that whistle blowing is encouraged.

ANDROVETT: Can we talk about HIPAA [Health Insurance Portability and Accountability Act] for a second? For years, lawyers have been warning their clients, not only in the health care field but elsewhere, "Hey, this is going to rock your world." Most laypeople really didn't have HIPAA on their radar until the University of Texas football player got hurt and Mack Brown refused to disclose the nature of his injuries because of HIPAA; and then, all of a sudden, people paid attention. Have the bugs, if you will, been worked out of HIPAA?

POPPITT: Well, we just got more HIPAA this year. So, I'd say, to the extent we worked out old bugs, we have new ones to work out now that we have some enforcement regulations. We'll just have to see how it all plays out. I think there are still lots of questions that haven't been answered about HIPAA. In fact, I'm going to a conference soon in which one of the sessions is entitled, "Should we just ditch HIPAA and start over? Do we need a new HIPAA?" So I would say that we have not worked it out. I think a lot of people have HIPAA plans, and most people have an idea what HIPAA is; but I think, for the most part, it's caused more problems than it has really protected privacy.

ANDROVETT: And that's why?

POPPITT: I think it's very complicated. And a lot of people don't really understand what the point is, and so, they make it into a lot of things it really isn't. I mean, for instance . . . if you have a case with the Attorney General's office and they come in and take your documents from you in some sort of enforcement action, and . . . you want to see what they've got [and] what they're relying on in making their allegations [but] they're saying they can't give them to you because of HIPAA. It's just created all kinds of crazy regulatory things like that. . . . I don't think that's what HIPAA was intended to protect.

NELSON: From a civil litigation perspective, the Boards are HIPAA-exempt with respect to any records they want to obtain. And in malpractice actions, I don't think that we really see a lot of calls. Chapter 74 now provides that a complainant is supposed to give us very specific statutorily mandated HIPAA compliant medical authorization. With respect to ordering medical records in civil litigation, in that one limited aspect, it's made our jobs a little bit easier.

ANDROVETT: I meant to ask this earlier, and Susan, you may be the right person to ask about this. Again, I'm drawing on general perception, as opposed to the more sophisticated knowledge that you have, but the general perception is now that we've had tort reform, doctors and hospitals, for the most part, are

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immune from litigation. Outside of the doctor malpractice context, are you seeing areas where it seems like there is not less, but actually more litigation against, let's say, hospitals?

NELSON: I don't know about so much more litigation against hospitals, but we again go back to just more complaints before the Boards. . . . [T]ypically we see the plain vanilla complaints filed by patients or family members with respect to the Board, and now what we're seeing, in a post-tort reform world, is a complaint by one physician against another physician or by one health care provider against another health care provider as a way to use a system that he or she may perceive as an effective means to fuss at another health care provider, valid or not. Sometimes that can be made abated by economic concerns, or as a result of peer review or quality assurance issues at a hospital. So we're seeing the use of the administrative system more frequently in a post-tort reform world.

ANDROVETT: Have there been administrative law decisions that have given you pause over the last couple of years?

NELSON: I will say that, from my perspective, over the last three or four years, the various Boards in Austin have become much more aggressive in their investigations; and partly because they're better funded, and in part because I think they take their duties to the public seriously. We have certainly received proposed orders that we feel are not supported by the evidence. I don't know that the orders are necessarily more egregious or stringent as a result of tort reform. We are grateful for the fact that we do have a pretty clear remedy if we disagree with the Board. . . . I have found that generally the Boards' proposed orders and recommendations have been fair. Not always, but generally fair.

ANDROVETT: . . . Almost every panel that we do, we get into a discussion about electronic records. . . . In fact, *Texas Lawyer* has had several roundtable discussions about the new e-discovery rules. Maybe this is incorrect, but health care providers are sort of this super-industry when it comes to electronic discovery and the storage of electronic information. You're dealing with privacy issues, very personal intimate issues, and medical records. What are you seeing out there in the landscape regarding either the storage of electronic information or how the e-discovery rules are going to hash out in the health care field?

LOVETT: . . . I think the change in the federal rules caught a lot of companies flatfooted; but the health care industry, which has always had protection of information issues, is probably better on storage and backup just because of legacy issues. But this e-discovery portion is not something that they've necessarily looked at closely, as many industries have not. Other than perhaps the financial services and securities industry, we are probably the largest regulated field. And one of the things I'm seeing is [that] there has been a lot of thought given in balancing e-discovery interests and HIPAA and privacy concerns. It's the age of the BlackBerry. It's the age of physicians giving curbside consults. So where do you draw the line? . . . At what point do you have to start turning over physician home computer hard drives or BlackBerry text messaging? Those are things I think people do every day, and they don't think about [it]; in addition to the bigger issues, the broader issues of storage, maintenance, backup [and] metadata. I think there's kind of a three-step approach, and I think it hasn't quite been tested. First, you have to assess where you are in terms of your electronic discovery as a health care entity provider, remembering that with HIPAA, this also extends to insurance companies, claims professionals [and] employers who are self-insured. So you have to look at that. After you figure out where you are, you have to figure out how you're going to deal with the interplay between HIPAA and your electronic discovery concerns; and then, you have to come up with a comprehensive plan. And I think what is alarming some folks, especially medical records departments in hospitals who have just about mastered HIPAA, is that now we have this whole new set of information which, particularly in the health care field, is going to be harder to gather. . . . [E]ven though the consults may be anonymous, where you literally have hundreds of folks involved, perhaps, in one patient's care, just on a consult standpoint, it's hard to gather all information and keep it in a way that it would be responsive, because, again, penalties there are pretty severe. I did have a hospital start calling me and saying, "I just read something called *Zubalake*."[*Zubulake v. UBS Warburg*, 2004 WL 1620866 (S.D.N.Y. July 20, 2004]. And I said, "Which one?" I mean, it's a frightening concept, as this starts getting mobilized. There are a lot of vendors out there dealing with it, but what I frequently see with outside vendors, and many of them are very good, is that they say, "We can help you with e-discovery or we can help you with HIPAA." I haven't seen one yet that says, "We can help you with e-discovery and HIPAA." I think that's going to be a niche market.

ANDROVETT: And not to put you on the spot, but refresh my memory about *Zubalake*. Is that a case where they were trying to control the flow of discovery, the flow of electronic information, and got caught? Basically, people were violating their own rules.

LOVETT: Yes. It basically set the stage for the adoption of the new federal rules. It was the case where we started seeing where the courts were going with respect to the e-discovery standards, and there are so many things we don't think of day-to-day. Fifteen years ago, I was thinking it was really nice to have a word processor. I wasn't thinking about having my documents scrubbed, whatever that means. And now, it's changed so that I have to scrub my documents even before I e-mail them to colleagues in other offices. So there's a lot there. And I forget how many there were for *Zubalake*, I believe there were six, but that case and its progeny [and] now our subsequent rules, give us a lot to think about in terms of maintaining data. And for health care providers there are some overlapping concerns. . . . Are your electronic appointment books that you keep something that have to be preserved? A lot of physician offices now preserve that. So it's going to be, I think, a quagmire for a little while, until we get some clear guidance.

ANDROVETT: And these will be decisions made by judges in litigation, typically?

LOVETT: Typically so, unless we get some new regulations that come out to support that on the HIPAA side. But again, I don't think there's been much interplay between the HIPAA regulating, the HIPAA regulated bodies, and [the] folks dealing with e-discovery. That's a creation of judicial mechanisms. I'm not sure the judges are always thinking about that when they come to that particular inquiry.

ANDROVETT: . . . There has been much in the general media about the plight of the uninsured and the impact that they're having on health care providers. What is the long-term impact? What are you seeing in your crystal ball about the impact on the uninsured in the health care industry in this state and in this country?

POPPITT: Well, Texas tends to have one of the higher rates of uninsured, and it puts a big burden on the emergency rooms for our hospitals. Every time somebody comes into the emergency room at a hospital more tests are done on them than would be the case if they went to a doctor that they regularly saw. Because this is a new person, every single time they come into the emergency room, and there is not a history of, "Well, I took your blood last time when you were here so I don't need to do that again. We just did an MRI six months ago so we don't need to do that again." There's none of that. So every time you come into the emergency room they have to treat you as if you were a totally unknown entity, and will have to run many, many more tests than they would have otherwise. So being treated in the emergency room is one of the most expensive places and inefficient places we can be treated, and that just creates a great deal of stress on the finances of hospitals. And I see lots of ways in which hospitals are trying to come up with these sort of transition clinics, where a patient who came into the ER uninsured and couldn't

pay, rather than continuing to come back and get continued treatment from the ER, this transition clinic would be available for 20 days, until you're stable, or something like that. These ideas are just now being tossed around. Nothing is firm yet, but a couple of hospitals I know are looking at it. Because overall, if you have these underinsured patients, they are not getting the treatment they need, by the time a diabetic patient comes to the hospital, they're close to comatose, as opposed to going to their doctor for continual care so that they have their insulin in shape. And this creates a less healthy population, which down the road is just more and more expensive.

ANDROVETT: . . . What are the issues that will occupy your clients most immediately, and therefore, will occupy you in the next year or so?

LOVETT: On the litigation side, we're seeing more health care entities doing battle with health care entities. One of the things that you hear is, when the economy is good, like it is now, litigation is not so good. I found that not to be true in the health care industry, largely because of the types of tensions we discussed. We're seeing less and less alliance between various health care providers because there's competition for less dollars out there, and I think that's important. I also think, on the pharmaceutical side, we haven't talked about this, but one of the things Congress is going to be looking at coming up is . . . for five years we've had this hiatus where the maker of a name-brand drug would literally pay to delay any generics to the market. And I think that with the change in Congress that will be something [to watch] on the pharmaceutical side. We see a lot of lobbying effort being put into that. That's a relatively easy issue and consumer friendly issue to take up.

ANDROVETT: Susan, looking ahead a year or two, longer if you'd like, what are the issues that are going to occupy your clients and you and your practice?

NELSON: With respect to civil litigation, post-tort reform, one of the issues . . . I think physicians and health care providers are going to have to wrestle with is whether or not to settle a case that appears to be at or near the policy limits. And I think that before [tort reform] we were certainly inclined to see more physicians who were willing to take their cases to trial. I think we're going to see litigation in the areas of how the statute defines emergency medical services and how the complaints have to be [drafted], and we're going to see litigation in the area of what constitutes an economic damage. With respect to Board actions, physicians are going to have to determine how aggressive they want to be in pursuing those with respect to licensing issues. And one of the things we talked about earlier was your question, "What keeps folks up at night?" With respect to my clients, it is Board actions. It's whether or not the Board's going to make them take their jurisprudence exam. So that's the main issues we see.

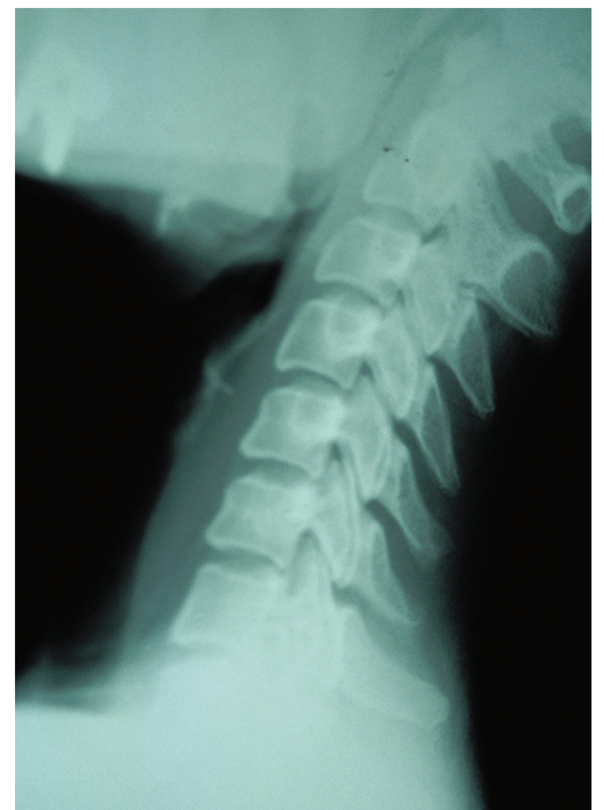
ANDROVETT: Kathy, what are you seeing as you look out over the next couple of years of your clients and your practice?

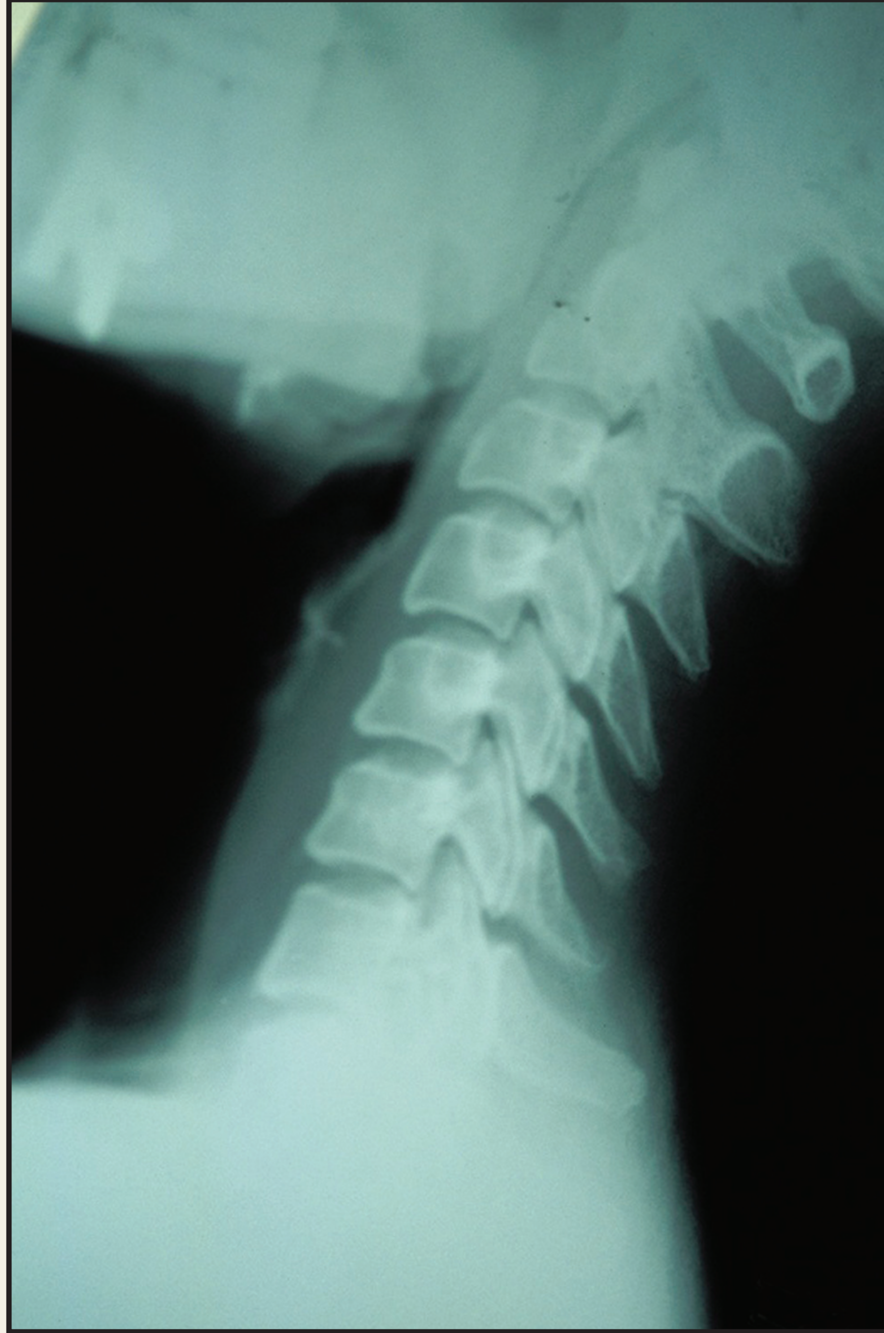
POPPITT: A couple of things. I think overall, fraud and abuse and all of its aspects are going to be a driving force of many things. As we've said, both the federal and the state governments have really beefed up their enforcement of the federal and state statutes; a lot of resources, money and people are being put into enforcement actions. And I think whistle blower cases, plus government-brought cases against all kinds of providers are going to be a real issue. And that requires us to be really on top of the ventures we enter into [and] the contracts we enter into with vendors and with health care providers. And it requires us to be on top of our billing, and be sure that the people that we've got doing our billing and doing all those other kinds of bookkeeping are on top of all the latest requirements and regulations. And so, I think that it's going to eventually require more of a financial burden on behalf of the providers to deal with and make sure that they are safe from any kind of enforcement action. I also think that paying for performance, which we haven't really touched on today, is a big trend. In fact, I have talked to two attorneys this week at a firm where they're doing nothing but creating pay-for-performance programs for their providers.

ANDROVETT: And that is?

POPPITT: Kind of the niche now. Pay for performance is a federal push by CMS for both hospitals and physicians and other types of providers. You can increase your rate of Medicare reimbursement if you meet certain criteria, if you have lower infection rates and if you spend more time with your patients. There are various factors, [and] if you meet those, then it increases your rate of reimbursement. Now, that's just all sort of budding at this point. There are requirements that are being talked about, it's [been] put into some new legislation, but nobody is real sure how that works or is going to work. CMS is working on that right now, but I think it's a way to increase your reimbursement, so it's obviously going to be something that we need to be able to advise our clients on how to comply with. So I think those are two of the big ones. Plus, I think watching the Democratic Congress and seeing what different ideas that they may have than the Republicans have had, and changes they may want to make, which we may or may not be ready for.

RICHARDS: We have, on the panel, a consensus about enforcement. I agree that we're going to see a lot more enforcement from the government, state and federal. And I think it's going to change a little bit as far as the mix of people who are seeing problems with it. The days of the . . . billion dollar settlements are gone. I think the low hanging fruit has been picked, and it's moving down to smaller sized providers now. And we're seeing it with smaller hospitals; we're seeing it with individuals, whereas previously, unless it was a high profile matter or something that the government had a particular interest in, as far as an entity, you didn't see that kind of enforcement. So I think we're going to see a lot more of that. I think also we're going to see, Mary-Olga and Susan both touched on this, competition between providers. While there are additionally quite a few additional suits filed — provider against provider — I'm seeing situations where one provider is using enforcement mechanisms against other providers. For example, MTALA, the Emergency Medical Treatment and Active Labor Act, has a lot of restrictions on patient dumping, transfer, stabilizing [and] who you have to take and who you can't take. I've seen [it] two or three times in the last year where one hospital will use a complaint filed under MTALA against another hospital as a competitive mechanism. Similarly, it used to be that the large entities were the recipients of complaints of whistle blower actions. Now we're beginning to see, such as here in Dallas not long ago, one relatively large health care entity file a complaint against another for jumping the gun on the moratorium against specialty hospitals. Previously, you never would see that. And I think also, as everybody has said, we're going to have to face additional restrictions on revenue and be as creative as possible in creating new ways to generate funds legitimately. ❖





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