

# **CHANGES IN HEALTH CARE LAW IN 1993 BRING NEW CHALLENGES FOR PROVIDERS**

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*In chaos, there is opportunity.<sup>1</sup>*

## **INTRODUCTION**

While Congress is debating the merits of the American Health Security Act of 1993, the health care system in Indiana is already in a state of flux. This year, changes have occurred in medical malpractice law and in the rules promulgated by the Indiana State Department of Health and the Office of the Secretary of Family and Social Services. These changes, in conjunction with changes in federal Medicare and Medicaid law, are influencing providers to form health care networks and other alliances to help them survive the changes that may result from health reform. Indiana health care providers and lawmakers are not waiting for national health reform: they have decided that the time for change has arrived.

This Article will set forth a description of as many of the recent cases and regulatory changes affecting health care practitioners as possible.<sup>2</sup> The Article will first survey the cases involving the Indiana medical malpractice statute. It will then provide a discussion of cases involving the state's Medicaid program, changes in the law affecting the limitation of health insurance benefits for individuals with acquired immune deficiency syndrome (AIDS), and cases involving peer review and physician relationships. Finally, the Article will discuss some important changes in federal health care law, including the anti-referral provisions of the Omnibus Budget Reconciliation Act of 1993 (OBRA 1993), the proposed safe harbors under the Medicare-Medicaid Anti-Kickback Statute, and cases decided under the Emergency Medical Treatment and Labor Act.

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1. Chinese proverb.

2. Specifically, the Article covers the time period from January 1, 1993 to December 30, 1993.

## I. MEDICAL MALPRACTICE

Several opinions involving the Indiana Medical Malpractice Act (Act)<sup>3</sup> were issued by the Indiana courts this year. Of particular interest are the opinions utilizing the "new" standard of care articulated by the Indiana Supreme Court in 1992 and describing various actions within the scope of the Act.<sup>4</sup>

### A. Proving the Standard of Care

In 1992, the Indiana Supreme Court decided to join the majority of courts nationwide abolishing the modified locality rule.<sup>5</sup> In *Vergara ex rel. Vergara v. Doan*,<sup>6</sup> the parents of a newborn child asked the Indiana Supreme Court to consider the abandonment of the modified locality rule in medical malpractice cases in Indiana—a challenge Chief Justice Shepard accepted, describing the new standard as "a relatively modest alteration of existing law."<sup>7</sup> The following rule

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3. IND. CODE §§ 27-12-1-1 to -18-2 (1993) (previously codified at IND. CODE §§ 16-9.5-1-1 to -10-5). Practitioners unfamiliar with the Indiana Medical Malpractice Act may find helpful background and commentary in Eleanor D. Kinney et al., *Indiana's Medical Malpractice Act: Results of a Three-Year Study*, 24 IND. L. REV. 1275 (1991).

4. Because of space limitations, it is not possible to discuss all of the state cases impacting the practice of medical malpractice law that were issued since the last Survey Issue was printed; therefore, I have chosen only a few cases to highlight. In addition, some cases of interest have been published since the end of the time frame for this Article. Therefore, the reader may also wish to review the following cases: *Hoskins v. Sharp*, 629 N.E.2d 1271 (Ind. Ct. App. 1994) (trial court has jurisdiction to order compliance with the requirements for formation of a medical review panel and defendant's insistence on a properly formal panel does not constitute waiver); *Mayhue v. Sparkman*, 627 N.E.2d 1361 (Ind. Ct. App. Jan. 31, 1994) (adopting the loss of chance doctrine for compensation for the lost chance of recovery); *Weaver v. Robinson*, 627 N.E.2d 442 (Ind. Ct. App. 1993) (holding that "[w]here there is a unanimous medical review panel determination favoring the defendant and no countervailing expert opinion, the defendant is entitled to a judgment as a matter of law" and that the physician's negligence could not be imputed to the hospital because the physician acted as an independent contractor); *Vogler v. Dominguez*, 624 N.E.2d 56 (Ind. Ct. App. 1993) (holding that the plaintiffs failed to provide evidence warranting an inference of negligence and could not rely on the doctrine of *res ipsa loquitur* because they failed to establish standard of care applicable to the hospital's employees); *Mundy v. Angelicchio*, 623 N.E.2d 456 (Ind. Ct. App. 1993); *Jordan v. Deery*, 609 N.E.2d 1104 (Ind. 1993) (holding that the issuance of a medical review panel decision does not shorten the time a plaintiff would otherwise have to file a complaint in state court); *Blackden v. Kaufman*, 611 N.E.2d 663 (Ind. Ct. App. 1993) (holding that the trial court did not err in dismissing the plaintiffs' claim with prejudice for failure to submit evidence or to notify the medical review panel that no evidence will be submitted, causing the panel to fail to render an opinion in 180 days); *McGee v. Bonaventura*, 605 N.E.2d 792 (Ind. Ct. App. 1993) (holding that a certified unanimous opinion of the medical review panel negated the existence of a genuine issue of material fact).

5. A description of the locality rule and the modified locality rule and their abandonment by various courts can be found in John K. Johnson, Jr., Note, *An Evaluation of Change in the Medical Standard of Care*, 23 VAND. L. REV. 729 (1970).

6. 593 N.E.2d 185 (Ind. 1992).

7. *Id.* at 188.

was then articulated as the new standard for medical malpractice cases in Indiana:

[A] physician must exercise that degree of care, skill, and proficiency exercised by reasonably careful, skillful, and prudent practitioners in the same class to which he belongs, acting under the same or similar circumstances. Rather than focusing on different standards for different communities, this standard uses locality as but one of the factors to be considered in determining whether the doctor acted reasonably. Other relevant considerations would include advances in the profession, availability of facilities, and whether the doctor is a specialist or general practitioner.<sup>8</sup>

Justice Givan in a concurring opinion noted, however, that the "new standard" enunciated by the court is not a new standard at all.<sup>9</sup> Instead, he observed that the new standard does not materially alter the modified locality rule because the facilities available to the physician and the physician's training as either a generalist or a specialist should be considered.<sup>10</sup> Therefore, he concluded, "the majority has articulated a distinction without a difference. I would not confuse the issue by purporting to do away with the modified locality rule."<sup>11</sup> The commentators agreed.<sup>12</sup>

This year, at least two Indiana cases have recited the *Vergara* standard. In *Widmeyer v. Faulk*,<sup>13</sup> the Indiana Court of Appeals stated that regardless of the "change" in the test used to determine whether the standard of care has been met, a plaintiff must submit expert medical testimony if the injury alleged is outside the "common knowledge" of a jury.<sup>14</sup> The plaintiff, Teresa Widmeyer, needed to have a tooth extracted that was the back anchor to a three-tooth bridge. The tooth could not be extracted until the bridge was severed. Ms. Widmeyer visited an oral surgeon, Dr. Faulk, who used a low-speed handpiece with a

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8. *Id.* at 187.

9. *Id.* at 188 (Givan, J., concurring).

10. *Id.* (Givan, J., concurring).

11. *Id.* at 185 (Givan, J., concurring).

12. In one article a commentator stated that the change in the standard would not have an impact because technological advances have emerged in communication, travel, and education, and the disparity between urban and rural physicians is no longer present. Linda Pence, *New Standard of Care in Medical Malpractice Cases?*, INDPLS. BUS. J., Dec. 14-20, 1992, at 8B. This commentator concluded: "For this reason, the *Vergara* ruling should have virtually no impact in medical malpractice cases. In fact, the court itself described its ruling as 'a relatively modest alteration of existing law.' Thus, in the great scheme of things, the status quo has not been disturbed." *Id.* Similarly, in a later case, the Indiana Supreme Court reemphasized that the standard of care has not changed too drastically when Justice Krahulik described the new standard as a "shortened" definition of the standard of care. *Culbertson v. Mernitz*, 602 N.E.2d 98, 100 (Ind. 1992).

13. 612 N.E.2d 1119 (Ind. Ct. App. 1993).

14. *Id.* at 1123.

separating disc attachment to cut the solder joint of the bridge. In the process, Ms. Widmeyer's tongue was lacerated. Unfortunately for Dr. Faulk, he was not a "qualified health care provider" under the Indiana Medical Malpractice Act, which allowed Ms. Widmeyer to file a complaint in superior court for his alleged medical malpractice in treating her tongue and tooth.<sup>15</sup> The trial court granted summary judgment in Dr. Faulk's favor.

The court of appeals noted that the applicable standard of care is "that degree of care, skill, and proficiency exercised by reasonably careful, skillful, and prudent practitioners in the same class to which he belongs, acting under the same or similar circumstances."<sup>16</sup> The court added that generally the plaintiff must present expert medical testimony to establish that the practitioner's conduct fell below the standard of care, although conduct a jury can understand without technical explanation does not require expert testimony.<sup>17</sup> Ms. Widmeyer's evidence on summary judgment consisted of an affidavit from a general dentist who admitted that he was not competent to testify on the standard of care for an oral surgeon. The court concluded that Ms. Widmeyer did not submit evidence that raised a genuine issue of material fact concerning Dr. Faulk's conduct and that the facts were not within the "common knowledge" of a jury, which would negate the need for the submission of such evidence.<sup>18</sup> The court also rejected Ms. Widmeyer's argument that the doctrine of *res ipsa loquitur* applies because she "failed to introduce expert testimony that her injury is one that ordinarily occurs only in the absence of due care."<sup>19</sup>

In another case, the Indiana Court of Appeals again decided against a plaintiff who failed to provide sufficient expert testimony to demonstrate that an allegedly negligent practitioner engaged in conduct that fell below the standard of care. In *Bonnes v. Feldner*,<sup>20</sup> the plaintiffs, Ronald and Christine Bonnes, sued a family physician and an internist who performed a treadmill stress test on Ronald Bonnes. Mr. Bonnes, who was experiencing intermittent chest pain, visited Dr. Feldner, his family physician, who referred him to Dr. Lanman for

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15. See IND. CODE § 27-12-3-1 (1993) (previously codified at IND. CODE § 16-9.5-1-5).

16. *Widmeyer*, 612 N.E.2d at 1122 (quoting *Vergara*, 593 N.E.2d at 187).

17. *Id.* The exception to the rule that expert testimony is required, which is generally referred to as the "common knowledge" exception, is applicable in cases in which negligence may be inferred from common knowledge or in:

situations in which the complained-of conduct is so obviously substandard that one need not possess medical expertise in order to recognize the breach. It is otherwise when the question involves the delicate inter-relationship between a particular medical procedure and the causative effect of that procedure upon a given patient's structure, endurance, biological makeup, and pathology. The sophisticated subtleties of the latter question are not susceptible to resolution by resort to mere common knowledge.

*Malooley v. McIntyre*, 597 N.E.2d 314, 319 (Ind. Ct. App. 1992).

18. *Widmeyer*, 612 N.E.2d at 1123.

19. *Id.* at 1124. Cf. *Wright v. Carter*, 622 N.E.2d 170 (Ind. 1993) (affirming summary judgment for radiologist because the plaintiff failed to produce expert medical testimony).

20. 622 N.E.2d 197 (Ind. Ct. App. 1993).

a cardiac stress test. Mr. Bonnes experienced chest pain during the procedure, but his blood pressure, pulse, and electrocardiogram (EKG) did not show any abnormalities.

Eight months later, Mr. Bonnes experienced chest and jaw pain, shortness of breath, and numbness and swelling of his left hand. He was diagnosed with angina. Mr. Bonnes later sought the advice of yet another physician, a cardiologist, who performed a coronary angiogram, attempted to perform an angioplasty, and referred Mr. Bonnes for open heart surgery. Mr. Bonnes later sued Drs. Feldner and Lanman.

After the decision of a medical review panel was issued, Mr. Bonnes proceeded to court and a jury trial was held. At the close of the plaintiffs' case, Dr. Feldner was granted judgment on the evidence.<sup>21</sup> On appeal, the court noted that the appropriate standard of care is

that degree of care, skill, and proficiency exercised by reasonably careful, skillful, and prudent practitioners in the same class to which he belongs, acting under the same or similar circumstances. Locality, advances in the profession, availability of facilities, and whether the doctor is a specialist or general practitioner are factors to be consider [sic] in determining whether the doctor acted reasonably.<sup>22</sup>

The court reasoned that because Dr. Feldner is a family physician, expert testimony was required of what other similarly situated family physicians would have done under the circumstances.<sup>23</sup>

The plaintiffs introduced the expert testimony of a cardiologist practicing in the south Chicago-northwest Indiana area. The expert testified with regard to how he would treat Mr. Bonnes's case as a cardiologist, not how the case would be treated by a similarly situated family physician acting under similar circumstances.<sup>24</sup> In fact, the expert testified that he was "not totally passing judgment on a GP [general practitioner] or family practitioner in that their mind set is somewhat different, and it becomes very difficult to put myself in their shoes."<sup>25</sup> The court affirmed the trial court's grant of judgment on the evidence because the plaintiffs failed to produce expert testimony on the appropriate standard of care.<sup>26</sup>

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21. Dr. Lanman received a favorable verdict, which was not the subject of this appeal.

22. *Bonnes*, 622 N.E.2d at 199 (quoting *Vergara*, 593 N.E.2d at 187) (citation omitted).

23. *Id.*

24. *Id.* at 200.

25. *Id.*

26. *Id.* at 201. The court also noted that the submission of an uncertified copy of the medical review panel's opinion cannot be considered as evidence in determining whether a *prima facie* case of medical malpractice has been made. *Id.*

### B. Actions Within the Scope of the Act

1. *The Good Samaritan Law.*—Indiana law provides protection for individuals who render emergency care at the scene of an accident. This statute, known as the Good Samaritan Law, states:

Any person, who in good faith gratuitously renders emergency care at the scene of an accident or emergency care to the victim thereof, shall not be liable for any civil damages for any personal injury as a result of any act or omission by such person in rendering the emergency care or as a result of any act or failure to act to provide or arrange for further medical treatment or care for the injured person, except acts or omissions amounting to gross negligence or wilful or wanton misconduct.<sup>27</sup>

This year, the Indiana courts were asked on two occasions to address arguments that a practitioner's conduct was within the scope of the Good Samaritan Law and therefore, was outside the scope of the Medical Malpractice Act.

First, in *Beckerman v. Gordon*,<sup>28</sup> a physician appealed the denial of his summary judgment motion on the grounds that the court improperly applied and misconstrued the Indiana Good Samaritan Law. The original action was filed by the administrator of the estate of Mary Ann Gordon. Mrs. Gordon experienced chest pain that radiated down her left arm early one morning. Her husband called Dr. Beckerman, who made a house call, diagnosed Mrs. Gordon with "pleurisy," and gave her medication for pain and nausea. Mrs. Gordon's condition did not improve, and within an hour, she was in full cardiac arrest. Mrs. Gordon was transferred by ambulance to the nearest hospital, but she never regained consciousness and died. Mr. Gordon, as the administrator of his wife's estate, sued Dr. Beckerman after an autopsy showed that Mrs. Gordon died of a coronary artery blockage.

Dr. Beckerman claimed that he was protected from liability under the Good Samaritan Law and that the applicable standard of care was whether his conduct constituted gross negligence or wilful or wanton misconduct. When these arguments were made to the medical review panel, Dr. Beckerman was ordered to delete them from his submission. An interlocutory appeal from the panel's order was denied. After the medical review panel found his conduct to be negligent and the matter was brought before a trial court, Dr. Beckerman again made arguments that his conduct fell within the scope of the Good Samaritan Law. The trial court sustained the estate's motion to strike Dr. Beckerman's Good Samaritan Law defense.

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27. IND. CODE § 34-4-12-1 (1993).

28. 614 N.E.2d 610, *reh'g denied*, 618 N.E.2d 56 (Ind. Ct. App. 1993).

On appeal, the court noted that every state has enacted a Good Samaritan Law.<sup>29</sup> The court reasoned, however, that the Indiana Good Samaritan Law differs substantially from those enacted in other states because, by its clear language, it is not applicable to *all* emergencies.<sup>30</sup> Furthermore, a previous version of the statute stated that it was applicable to emergency care rendered “at the scene of an accident, *casualty, or disaster* to a person injured therein. . .”<sup>31</sup> The court then struggled with the definitions of the terms “accident” and “emergency” and concluded:

The legislature has not provided a definition of the term “accident” as it is used in the Good Samaritan Law. While the term has been defined in many ways in various contexts by numerous courts, we can, at least, agree with the observation that “[a]ccident’ is a word of varied meaning and of no fixed legal signification.”

Generally, an “accident” can be defined as a sudden, unexpected event. An “emergency” can be described as an unexpected condition or set of circumstances requiring immediate attention.

We perceive that the distinction between an “accident” and an “emergency” is that an accident is a single discrete *event* causing unexpected consequences, while an emergency is a *condition* that has unexpectedly arisen. An “emergency” can be thought of as the effect of an “accident,” but not all emergencies are the result of accidents, as the condition could develop from a gradual series of events, and all accidents do not necessarily create emergencies. The term “emergency” has a broader scope than the word “accident” and the terms are not synonymous. Therefore, as used in the Good Samaritan Law, we conclude the legislature intended “accident” to mean a type of sudden calamitous event, and not all situations that might require immediate action.<sup>32</sup>

Therefore, the court concluded that the motion to strike the Good Samaritan Law defense was not in error because Dr. Beckerman did not render care at the scene of an accident.<sup>33</sup>

Judge Sullivan dissented, claiming that Dr. Beckerman should have been allowed to present the Good Samaritan Law defense to the trier of fact.<sup>34</sup> Judge Sullivan’s disagreement with the majority opinion stemmed from his interpretation of the terms “accident” and “emergency.” In his opinion, he stated:

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29. *Id.* at 612.

30. *Id.* at 612-13.

31. *Id.* at 613 (quoting 1963 Ind. Acts c. 319 § 1) (emphasis added).

32. *Id.* (citations omitted).

33. *Id.* at 613.

34. *Id.* at 614 (Sullivan, J., dissenting).

Were it not for definitions of "accident" contained in numerous Indiana case decisions, I might find the majority's analysis of the legislative history of our statute more persuasive. By deleting "casualty or disaster" from the statute, it might appear . . . that the General Assembly did not intend that every rendering of emergency care should cloak the actor with the protection of the Good Samaritan defense. . . .

The word "emergency" describes the nature of the care administered in the particular situation, while "accident" describes the occurrence which brings about the necessity for that care. In order for the Good Samaritan defense to be available, the care must be of an emergency nature and in addition, that care must be required or indicated as a result of an "accident." An "accident," in its normal and common connotation, may be deemed to be "any mishap or untoward event not expected or designed."<sup>35</sup>

Judge Sullivan posited that the unexpectedness of the event must be considered from the point of view of the victim, not the point of view of the "reasonable man," which would be appropriate in insurance coverage and workers' compensation claims.<sup>36</sup> He reasoned that Dr. Beckerman was responding to "a cry for help," which was not distinguishable from a cry for help from a golfer on a golf course or a victim of a terrorist's acts.<sup>37</sup> Therefore, he would have allowed Dr. Beckerman to assert his defense in light of the factual issues raised by his interpretation of the statute.

The second case interpreting the applicability of the Good Samaritan Law in medical malpractice claims is *Steffey v. King*.<sup>38</sup> *Steffey* involved the appeal of a trial court's decision that the Good Samaritan Law was applicable to provide a physician with immunity for her actions in assisting with the birth of a child. Mildred Steffey was admitted to Community Hospital of Indianapolis for the delivery of her child. Her physician, Dr. King, decided to allow Mrs. Steffey to deliver the child through a normal vaginal delivery. Although Dr. King was present during Mrs. Steffey's early labor, he could not be found when she was ready to deliver. A nurse found another physician, Dr. Templeton, to assist with the delivery, but by the time she arrived, Mrs. Steffey's husband was already holding the baby's legs. Dr. Templeton used forceps to deliver the baby, who was cyanotic and had indentations on his head.

After submissions were made to the medical review panel, Dr. Templeton petitioned for a preliminary determination of law to determine the applicability of the Good Samaritan law and moved for summary judgment, which was

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35. *Id.* (Sullivan, J., dissenting) (citations omitted).

36. *Id.* (Sullivan, J., dissenting).

37. *Id.* at 615 (Sullivan, J., dissenting).

38. 614 N.E.2d 615, *reh'g denied*, 618 N.E.2d 56 (Ind. Ct. App. 1993).

granted in her favor.<sup>39</sup> On appeal, the court cited its decision in *Beckerman* and held that the trial court erred in granting summary judgment to Dr. Templeton.<sup>40</sup> The court reasoned:

In *Beckerman*, we strictly construed the Good Samaritan Law and concluded that the legislature did not intend for the Law to apply to all emergencies. Contrasting Indiana's statute with the laws of other states, we determined that the language employed in Indiana's version of the Good Samaritan Law was narrowly drafted to protect only those individuals who render emergency care at the scene of an accident or to the victims of such an accident. We decided that, as used in the Good Samaritan Law, "accident" was not synonymous with "emergency" and that the legislature intended "accident" to mean a type of sudden calamitous event, and not all situations that might require immediate attention.<sup>41</sup>

Judge Sullivan reaffirmed his analysis in *Beckerman*, but concurred with the majority's opinion.<sup>42</sup> He concluded that, from the perspective of the mother and the child, the delivery was not an "accident," but was instead, an expected event.<sup>43</sup>

On rehearing of both the *Beckerman* and *Steffey* cases, Drs. Beckerman and Templeton argued that prohibiting the use of the Good Samaritan Law defense will discourage physicians from responding to emergency situations. The court disagreed and added the following observation:

We cannot agree that our interpretation of the Good Samaritan Law will have such a "chilling" effect on doctors. The conclusion that a doctor is not entitled to immunity under the Good Samaritan Law is not the equivalent of a determination that the doctor acted negligently. The sudden emergency doctrine operates to modify the standard of care expected of individuals who are forced to respond to an emergency not of their own making. The fact that a doctor may have been responding to an emergency is therefore a factor to be considered in a medical malpractice action. Since the sudden emergency doctrine already provides physicians with a relaxed standard of care, we do not believe our strict construction of the Good Samaritan Law would seriously inhibit a doctor's decision to provide emergency medical assistance.<sup>44</sup>

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39. See IND. CODE § 27-12-11-1 (1993) (previously codified at IND. CODE § 16-9.5-10-1).

40. *Steffey*, 614 N.E.2d at 617.

41. *Id.*

42. *Id.* (Sullivan, J., concurring).

43. *Id.* (Sullivan, J., concurring).

44. *Beckerman*, 618 N.E.2d at 57 (citations omitted).

The court reasoned further that its decision is consistent with the reasonable expectation of patients.

Finally, Drs. Beckerman's and Templeton's arguments ignore the reasonable expectations of their patients. It cannot reasonably be concluded that a woman hospitalized for the birth of a child would consider that the standard of care of those attending her would depend upon whether or not they were on call or present at the hospital attending other patients when she was treated. If the Gordons had known that Dr. Beckerman would not be held to the established standard of care, they might well have elected to call an ambulance . . . instead of relying on his assistance.<sup>45</sup>

Based on these reasons, the court denied the physicians' request for a rehearing.<sup>46</sup>

2. *Ordinary Negligence*.—This year, the Indiana courts revisited the issue of when a health care provider's actions constitute ordinary negligence, rather than medical malpractice. In *Putnam County Hospital v. Sells*,<sup>47</sup> the Indiana Court of Appeals held that a patient's claim for injuries sustained when she fell from a recovery room bed was a claim for medical malpractice, not a claim for ordinary negligence.<sup>48</sup> Consequently, because the plaintiff failed to submit the claim to the Department of Insurance for review by a medical malpractice panel, the trial court did not have subject matter jurisdiction to hear her claim.<sup>49</sup>

In determining that the patient stated a claim for medical malpractice, the court distinguished previous cases in which a health care provider's negligent conduct was nonmedical in nature and was found to be ordinary negligence, rather than medical malpractice. The court first discussed the case of *Winona Memorial Foundation of Indianapolis v. Lomax*.<sup>50</sup> In *Lomax*, a patient brought a claim for damages after she tripped on a loose floorboard. The *Lomax* court held that a claim based on premises liability, such as Ms. Lomax's claim, does

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45. *Id.* at 57-58.

46. *Id.* at 58.

47. 619 N.E.2d 968 (Ind. Ct. App. 1993).

48. *Id.* at 972. The plaintiff's complaint stated:

5. That following surgery on January 8, 1991, Leann Sells was taken to the recovery room where she fell off of a table while under anesthesia sustaining injury to her face.

6. That the defendant, Putnam County Hospital, was negligent in failing to properly train and supervise its staff members with regard to proper procedure for monitoring patients in the recovery room following surgery.

7. That the Defendants were negligent in failing to properly monitor and observe Leann Sells in the recovery room, failing to insure that railings were in place on her recovery room bed and failing to take proper steps to insure that Leann Sells would not injure herself while under anesthesia.

*Id.* at 971.

49. *Id.* at 972.

50. 465 N.E.2d 731 (Ind. Ct. App. 1984).

not fall within the scope of the Medical Malpractice Act.<sup>51</sup> The court then turned to the case of *Harts v. Taylor-Nickel Hospital, Inc.*,<sup>52</sup> in which a patient brought a claim for injuries sustained when he fell from his hospital bed. The *Harts* court reasoned that the plaintiff's allegations were not "part and parcel of diagnosis and treatment which would subject his claim to coverage under the Act"<sup>53</sup> and held that the claim did not fall within the scope of the Act.<sup>54</sup>

In distinguishing the *Lomax* and *Harts* decisions, the *Putnam County* court discussed the case of *Methodist Hospital of Indiana, Inc. v. Rioux*,<sup>55</sup> which allowed a plaintiff to bring a claim for medical malpractice after she fell and broke her hip while she was a patient at Methodist Hospital. The court noted that, in the *Rioux* case, the plaintiff's complaint alleged that the hospital "negligently and carelessly failed to provide appropriate care . . . to prevent [her] fall and injury."<sup>56</sup> However, in the *Lomax* case, the plaintiff's complaint stated that Ms. Lomax "fell as a proximate result of defendant's negligent maintenance of the floor . . . in allowing a broken board to stick up in said floor,"<sup>57</sup> and in the *Harts* case, the plaintiff's complaint stated, "The direct and proximate cause of the fall of Plaintiff was the negligence of the Defendants."<sup>58</sup> The *Putnam County Hospital* court concluded that Ms. Sell's claim was more like the claim in *Rioux* than the claims in *Lomax* or *Harts*; therefore, her complaint alleged "that the Hospital's acts or omissions fell below the appropriate standard of care" and was therefore a claim for medical malpractice.<sup>59</sup>

3. *Sexual Conduct.*—The Indiana courts have also concluded that protection under the Act may be extended to a health care provider who has a sexual relationship with a patient. This determination, originally articulated in *Collins v. Covenant Mutual Insurance Co.*,<sup>60</sup> was reinforced this year when the Indiana Court of Appeals decided the case of *Dillon v. Callaway*.<sup>61</sup>

Linda Callaway was treated by Dr. Richard Chambers for multiple joint pain. Dr. Chambers suspected that the source of Ms. Callaway's pain was psychological in nature and began therapy sessions with her. During the next four years, Dr. Chambers and Ms. Callaway engaged in "bizarre and perverted

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51. *Id.* at 742.

52. 553 N.E.2d 874 (Ind. Ct. App. 1990).

53. *Id.* at 879.

54. *Id.*

55. 438 N.E.2d 315 (Ind. Ct. App. 1982).

56. *Putnam County Hosp.*, 619 N.E.2d at 971 & n.2 (quoting *Rioux*, 438 N.E.2d at 316).

57. *Lomax*, 465 N.E.2d at 742.

58. *Harts*, 553 N.E.2d at 879. Mr. Harts also filed an affidavit that stated, "I am not pursuing a claim for medical negligence arising out of this fall." *Id.*

59. *Putnam County Hosp.*, 619 N.E.2d at 971 & n.2.

60. 604 N.E.2d 1190 (Ind. Ct. App. 1992).

61. 609 N.E.2d 424 (Ind. Ct. App. 1993).

sexual conduct.”<sup>62</sup> Ms. Callaway was later hospitalized with major depressive symptoms, including severe depression with suicidal thoughts, anorexia, and agoraphobia. She subsequently settled a claim against Dr. Chambers for an amount with a present value of more than \$75,000 and petitioned the Patient Compensation Fund (Fund) for additional damages.

The Indiana Court of Appeals held that Ms. Callaway’s injuries were within the scope of the Indiana Medical Malpractice Act and that she could receive damages from the Fund.<sup>63</sup> In making this decision, the court distinguished the case of *Dillon v. Glover*,<sup>64</sup> in which the Indiana Supreme Court held that once a plaintiff settles a medical malpractice claim, proximate cause is no longer an issue.<sup>65</sup>

The *Glover* court looked at the relevant statute, which provides that after a medical malpractice claim is settled, a claimant may petition the court to recover additional damages from the Fund.<sup>66</sup> In reviewing this statute and drawing its conclusion, the court stated:

Obviously we cannot support the Fund’s view that the Statute allows the Fund to litigate a health care provider’s liability after the provider’s liability on a claim is settled. In our view the Statute contemplates that, upon a petition for excess damages, the trial court will determine the *amount* of damages, if any, due to the claimant, not whether the provider is liable for damages.<sup>67</sup>

In contrast, the *Callaway* court found that, unlike the issue of proximate cause, the issue of the compensable nature of a plaintiff’s claim is not foreclosed merely because the parties have entered a settlement agreement.<sup>68</sup>

The court then noted that a “significant exception” is applicable to “the generally developed rule that a typical physician’s sexual relationship with a patient [does] not constitute the rendition of health care services. . . .”<sup>69</sup> This exception applies when the physician mishandles the “transference phenomenon” during the therapy sessions.<sup>70</sup>

This phenomenon is “[t]he process whereby the patient displaces on to the therapist feelings, attitudes and attributes which properly belong to a significant attachment figure of the past, usually a parent, and responds to the therapist accordingly. . . . Transference is common in

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62. *Id.* at 425.

63. *Id.* at 426.

64. 597 N.E.2d 971 (Ind. Ct. App. 1992).

65. *Id.* at 973.

66. See IND. CODE § 27-12-15-3 (1993) (previously codified at IND. CODE § 16-9.5-4-3(1)).

67. *Dillon*, 597 N.E.2d at 973 (footnote omitted).

68. *Callaway*, 609 N.E.2d at 426.

69. *Id.*

70. *Id.* at 428.

psychotherapy. The patient, required to reveal her innermost feelings and thoughts to the therapist, develops an intense, intimate relationship with her therapist and often ‘falls in love’ with him. The therapist must reject the patient’s erotic overtures and explain to the patient the true origin of her feelings. A further phenomenon that may occur is countertransference, when the therapist transfers his own problems to the patient. When a therapist finds that he is becoming personally involved with the patient, he must discontinue treatment and refer the patient to another therapist.”<sup>71</sup>

Because Dr. Chambers took advantage of Ms. Callaway’s emotional status and history of sexual abuse as a result of mishandling the transference phenomenon, the court concluded that Ms. Callaway’s injuries resulted from the rendition of health care and were within the purview of the Act.<sup>72</sup>

### C. Summary of 1993 Medical Malpractice Cases

In deciding cases involving the scope of the Indiana Medical Malpractice Act, the Indiana courts continue to articulate a standard of care that, although not specifically stated in terms of locality, considers locality as a factor in determining whether the physician acted reasonably. The courts will also consider whether the physician is a generalist or a specialist. The courts are reluctant to stray from this standard through the application of the common knowledge exception or the doctrine of *res ipsa loquitur*. Therefore, a plaintiff should be prepared to present expert testimony to demonstrate that the health care provider failed to meet the standard of care.

In determining the scope of the Act, the courts have been unable to define lines that provide much comfort for providers. Although by becoming a qualified provider under the Act a health care provider may take advantage of the statutory cap on damages, the cap will not apply to acts the courts have determined are outside the scope of the Act. This year, the Indiana courts made clear that when a health care provider responds to a patient’s immediate medical needs, the provider is not entitled to protection under the Indiana Good Samaritan Law when the response is to an “emergency,” rather than an “accident.”

Whether a health care provider receives protection under the Act may also be governed by the skill used by the plaintiff’s counsel. Nonmedical acts by a health care provider are not within the scope of the Act when it is alleged that the nonmedical act is the proximate cause of the plaintiff’s injury. On the other hand, a provider’s nonmedical acts may fall within the purview of the Act if it is alleged that they caused the provider to fall below the standard of care.

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71. *Id.* at 427 (quoting *St. Paul Fire & Marine Ins. Co. v. Love*, 459 N.W.2d 698, 700 (Minn. 1990) (citation omitted)).

72. *Id.* at 428.

Finally, a physician's sexual conduct generally does not fall within the Act's protections. This general rule may be disregarded if the physician reacted inappropriately to a patient's response to psychotherapy.

## II. MEDICAID

In 1993, the Indiana courts were once again faced with the issues of whether the Indiana Medicaid statute includes a resource spend-down requirement and whether the reimbursement mechanism used for nursing facilities meets the requirements of the Boren Amendment.

### A. Medicaid Eligibility

This year the Indiana Supreme Court affirmed the opinion of the Indiana Court of Appeals in *Indiana Department of Public Welfare v. Payne*.<sup>73</sup> Hazen Payne was a construction laborer who developed leukemia and was hospitalized at the Indiana University Medical Center for five months, resulting in medical bills of approximately \$150,000. Payne applied for Medicaid benefits to cover these expenses, but was denied eligibility for the period for which he was hospitalized because he owned resources in excess of the financial requirements used by the Department of Public Welfare (Department).<sup>74</sup>

The trial court reversed the Department's decision and the court of appeals affirmed.<sup>75</sup> The decision of the court of appeals was based on the status of Indiana's Medicaid program as a "section 209(B)" program. Section 209(b) of the federal Medicaid statute allows state legislatures to elect to provide Medicaid benefits only to persons who would have been eligible under the state's Medicaid plan as it existed on January 1, 1972.<sup>76</sup>

When Payne applied for benefits, the Department used its resource limitation requirement to determine his eligibility for benefits.<sup>77</sup> The court rejected the

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73. 592 N.E.2d 714 (Ind. Ct. App. 1992), *aff'd*, 622 N.E.2d 461 (Ind. 1993). See Rolanda Moore Haycox, 1992: *A Year of Change for Our Health Care System*, 26 IND. L. REV. 1003, 1005-1007 (1993).

74. Although the cases described refer to the Department of Public Welfare, the state Medicaid program is now administered by the Office of Medicaid Policy and Planning. IND. CODE §§ 12-8-6-1, 12-15-1-1 (1993).

75. *Payne*, 592 N.E.2d at 726.

76. 42 U.S.C.A. § 1396a(f) (Supp. 1993); 42 C.F.R. § 435.121 (1992). On rehearing, the court stated that section 209(b) requires a state to provide Medicaid benefits to persons who would be eligible under the criteria as they existed on January 1, 1972, and these criteria apply even if they are more liberal than the criteria used in Supplemental Security Income (SSI) states. *Payne*, 598 N.E.2d 608, 610 (Ind. Ct. App. 1992).

77. An applicant or recipient is ineligible for medical assistance for any month in which the total equity value of all non-exempt resources exceeds the applicable limitation, set forth below, on the first day of the month:

(1) \$1,500 for the applicant or recipient, including the amount determined in (b) below, if applicable; or

Department's argument that its regulation is based on a statute providing for the resource limitations for Medicaid eligibility because the statute concerns only money, stocks, bonds, and life insurance.<sup>78</sup> The court also emphasized that the statute does not prohibit a resource spend-down, and that such a spend-down would be consistent with its principles because the applicant's resources would still have to meet the \$1,500 limitation as evaluated on the first day of the month.<sup>79</sup>

Furthermore, the court determined that the state's plan on January 1, 1972<sup>80</sup> and the Department's Medicaid Manual in effect until 1984 also allowed a resource spend-down.<sup>81</sup> The court concluded that because the Department may not use more restrictive criteria than those in place on January 1, 1972, it was required to allow Payne to spend down his income to attain eligibility for the state Medicaid program.<sup>82</sup>

After the Indiana Court of Appeals made its decision in the *Payne* case, the Seventh Circuit issued its opinion in *Roloff v. Sullivan*.<sup>83</sup> The apparent conflict between *Roloff* and *Payne* has created some confusion in the applicability of the resource spend-down rules articulated in *Payne*.<sup>84</sup>

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(2) \$2,250 for the applicant or recipient and his spouse.

*Payne*, 592 N.E.2d at 720 (quoting IND. ADMIN. CODE tit. 470, r. 9.1-3-17(a) (1988)).

78. *Id.* at 721. At the time of this case, the statute read:

An applicant for, or recipient of, medical assistance, is ineligible for that assistance if the total cash value of money, stocks, bonds, and life insurance owned by:

(1) the applicant or recipient exceeds fifteen hundred dollars (\$1,500), in the case of medical assistance to the aged, blind, or disabled.

(2) the applicant, or recipient, and his spouse exceeds two thousand two hundred fifty dollars (\$2,250), in the case of medical assistance to the aged, blind, or disabled.

*Id.* (quoting IND. CODE § 12-1-7-18.5(a) (1988)).

79. *Id.*

80. (c) Possession of intangible personal property with an available liquid cash value in excess of the standard resource allowance shall render an applicant ineligible for assistance, and *utilization of some of the resources down to the amount of the standard resource allowance is necessary before the applicant can be found eligible*.

(d) Possession of intangible personal property with an available cash value which has increased to be in excess of the standard resource allowance shall not make a recipient ineligible for assistance providing the recipient is willing to make the necessary adjustments and has taken immediate steps to do so.

*Id.* at 722 (quoting Ind. State Dep't of Public Welfare, r. 2-114).

81. *Id.* (citing IND. ADMIN. CODE tit. 470, r. 9-3-2(22.2), 9-4-3(12) (1979)).

82. *Id.* at 724.

83. 975 F.2d 333 (7th Cir. 1992).

84. The decision of the District Court for the Northern District of Indiana in *Roloff* was rejected by the *Payne* court.

In *Roloff*, it was determined that the Department was not required to allow Medicaid applicants to spend down their excess resources to become eligible for benefits. The

The *Roloff* case was brought by a class of persons who applied for eligibility under the Indiana Medicaid program, but were denied benefits because of the Department's "first day of the month" rule. The plaintiffs argued that the first day of the month rule is more restrictive than the Medicaid rules in effect on January 1, 1972 and therefore violated section 209(b) of the federal Medicaid statute.

The *Roloff* court interpreted section 209(b) "as an exception to the otherwise applicable rule that a state must provide Medicaid assistance to the categorically needy" or those entitled to social security income (SSI) benefits.<sup>85</sup> The court found that the plaintiffs were not entitled to benefits because they did not show they were entitled to receive SSI benefits for the months in which they were denied Medicaid benefits.<sup>86</sup> The court then stated:

Our resolution of the Section 209(b) issue therefore prevents us from giving blanket approval to Indiana's first day of the month regulation. Since the district court certified a class challenge to the first day of the month rule, the prudent course is to narrow the class definition to include only those similar to the named plaintiffs—namely, those persons denied Medicaid benefits because of the first day of the month rule *who also did not qualify for SSI benefits*.<sup>87</sup>

The court also found that section 1396a(a)(17), which requires the use of reasonable standards for determining eligibility, does not require the State of Indiana to adopt a resource spend-down rule for its Medicaid program.<sup>88</sup> In making this determination, the *Roloff* court noted that the first day of the month rule was upheld in *Payne*.<sup>89</sup> Therefore, the court reasoned, a resource spend-down is permitted, but not required.<sup>90</sup>

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determination was based on the following conclusion:

"[I]t does not matter whether Indiana had a first day of the month rule as of January 1, 1972, because under the § 209(b) option, a state could either retain eligibility criteria as restrictive as that in 1972 *or* adopt federal SSI standards. Since the first day or [sic] the month rule is an SSI standard, 20 C.F.R. § 416.1207(a), Indiana's option for that standard need not be measured against the state's procedures in 1972."

....

We cannot agree with the conclusion in *Roloff* that a resource spend-down cannot be used in conjunction with a first-day-of-the-month rule.

*Payne*, 592 N.E.2d at 723.

85. *Roloff*, 975 F.2d at 340.

86. *Id.* at 341.

87. *Id.*

88. *Id.* at 342.

89. *Id.* at 338.

90. *Id.* at 342.

Within ten days of the *Roloff* decision, the Indiana Court of Appeals held in *Indiana Department of Public Welfare v. Teckenbrock*,<sup>91</sup> that the Department must permit an applicant who otherwise qualifies for SSI benefits to spend-down his or her excess resources.<sup>92</sup> The Teckenbrocks brought this action after they were denied Medicaid benefits because their resources exceeded the \$2,250 limit for married couples.<sup>93</sup> They contended that because they met the SSI eligibility requirements and the Indiana Medicaid requirements effective on January 1, 1972, they could not be denied Medicaid benefits.

The Department contended that the Seventh Circuit's decision in *Roloff* was controlling. The court rejected the Department's argument because no claim was made that the Teckenbrocks were ineligible for Medicaid benefits because they did not qualify for SSI benefits.<sup>94</sup> The court reasoned that the Teckenbrock's case fell within the undecided issue in *Roloff* involving the class of persons who would be eligible for both SSI benefits and for Medicaid benefits under the rules effective on January 1, 1972.<sup>95</sup> The court then reaffirmed the holding in *Payne*<sup>96</sup> and found that "the 1972 medical assistance plan requires the [Department] to permit an applicant otherwise in need of medical assistance to become eligible immediately by spending down excess resources."<sup>97</sup>

One month after the *Teckenbrock* case was decided, the Indiana Supreme Court endorsed the holding in *Roloff*.<sup>98</sup> On appeal of the *Payne* decision, the Department argued that Hazen Payne did not liquidate his resources and did not make payment on his medical expenses by the first day of the months in issue and was therefore ineligible for Medicaid benefits for those months. The Department also argued that the Seventh Circuit's decision in *Roloff* provided

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91. 620 N.E.2d 740 (Ind. Ct. App. 1993).

92. *Id.* at 743.

93. The Teckenbrocks owed nursing home bills of over \$16,200, and owned life insurance policies with cash surrender values of \$2,573.70 and a checking account with a balance of \$1.08.

94. *Teckenbrock*, 620 N.E.2d at 741.

95. Inasmuch as the *Roloff* court expressly left "for another day" a decision affecting the class of persons who would be eligible for both SSI benefits under current federal standards and for Medicaid benefits under the rules in force in Indiana at the beginning of 1972, but to whom Indiana had denied Medicaid eligibility, the class into which the Teckenbrocks claim they fall, the *Roloff* court had no cause to consider whether Indiana employed a resource spend-down in 1972 as part of its medical assistance plan, as this court held in *Payne*, or the manner in which the system operated. And, this court likewise has no reason to reject the *Roloff* court's construction of § 209(b). The facts of this case simply do not put *Roloff* and *Payne* in conflict with one another, and the matter can be resolved simply by applying our decision in *Payne*.

*Id.* at 741-42.

96. *Id.* at 742.

97. *Id.* at 743.

98. Indiana Dep't of Pub. Welfare v. Payne, 622 N.E.2d 461 (Ind. 1993).

authority for the proposition that the section 209(b) exemption is only applicable when an applicant meets both the current SSI requirements and the Medicaid requirements effective on January 1, 1972.

The court agreed. In deciding to accept the rule articulated in *Roloff*, the Indiana Supreme Court stated:

We endorse the Seventh Circuit's conclusion in *Roloff* that SSI eligibility is a threshold requirement to participation in Indiana's Medicaid program. In Section 209(b) states such as Indiana, after an applicant has met this threshold eligibility requirement, the inquiry then focuses upon whether the applicant would have been entitled to benefits under Medicaid regulations existent on January 1, 1972. Thus, once an applicant has demonstrated SSI eligibility, he is then entitled to utilize Indiana's resource spend-down provision to, in turn, meet Indiana's standard resource allowance which is more restrictive than its federal counterpart.

As noted by our Court of Appeals, 42 U.S.C. § 1396a(r)(2) does permit Section 209(b) states to use more liberal methodologies in determining income and resource standards than those used by SSI states in evaluating Medicaid eligibility. Required resource spend-down is one such more liberal methodology which may be employed by Indiana since SSI permits but does not require resource spend-down. However, we conclude that Indiana did not intend to extend Medicaid eligibility to those who would not even qualify for benefits under SSI's more liberal requirements, because it did not endorse the more restrictive eligibility requirements by opting for participation in Medicaid under Section 209(b). Thus, the resource spend-down component of eligibility employed by Indiana in 1972 applies only after SSI eligibility requirements have been met. To hold otherwise would be to ignore the apparent intent manifested by Indiana's choice to participate in Medicaid as a Section 209(b) state.<sup>99</sup>

The court then stated that the court of appeals correctly stated in its opinion before rehearing that, in 1972, Indiana permitted a resource spend-down and that a resource spend-down was potentially available to Payne.<sup>100</sup> The court then concluded that meeting the SSI eligibility requirements is a prerequisite for the application of a resource spend-down rule.<sup>101</sup> Therefore, under current law, an applicant may become eligible for Medicaid benefits through the use of a resource spend-down only if the applicant meets the SSI eligibility requirements.

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99. *Id.* at 468 (citations omitted).

100. *Id.*

101. *Id.*

### B. Boren Amendment

The five-year battle over the validity of the rules used to determine Medicaid reimbursement for nursing facilities has also come to a rest. The Indiana Supreme Court held in October in *Indiana State Board of Public Welfare v. Tioga Pines Living Center, Inc.*,<sup>102</sup> that the rules used by the Indiana Department of Public Welfare to determine the *per diem* rates for the reimbursement of nursing facilities do not violate the Boren Amendment.<sup>103</sup>

The challenge to the Medicaid reimbursement system was brought by a class of 785 Medicaid-certified skilled and intermediate nursing facilities. The nursing facilities claimed that the Department's rules violated the Boren Amendment, which requires state Medicaid programs to provide for "reasonable and adequate" rates to meet the costs of care provided,<sup>104</sup> and that the tests for reasonableness used in determining the rates were not promulgated in accordance with law.<sup>105</sup>

The Medicaid *per diem* rates for nursing facilities were based on the recognition of the facility's allowable costs plus an incentive, subject to the limitation that the rates would be established at the lowest of a market area limitation, an incentive payment limitation, a maximum allowable annual rate increase limitation, rates charged to the general public for the same type of service, and the rate requested by the provider.<sup>106</sup> Summary judgment rulings

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102. 622 N.E.2d 935 (Ind. 1993), *cert. denied*, 114 S. Ct. 1302 (1994).

103. *Id.* at 944.

104. A State plan for medical assistance must—

(13) provide—

(A) for payment . . . of the hospital services, nursing facility services, and services in an intermediate care facility for the mentally retarded provided under the plan through the use of rates . . . for lower reimbursement rates reflecting the level of care actually received . . . which the State finds . . . are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards and to assure that individuals eligible for medical assistance have reasonable access . . . to inpatient hospital services of adequate quality . . .

42 U.S.C. § 1396a(a)(13)(A) (1988 & Supp. III 1991).

Indiana law provides a similar requirement:

Payment of nursing facility services under 42 U.S.C. 1396a(a)(13)(A) shall be determined in accordance with a prospective payment rate that is reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated facilities to provide care and services in conformity with state and federal laws, rules, regulations, and quality and safety standards, in accordance with rules adopted by the office.

IND. CODE § 12-15-14-2 (Supp. 1992).

105. *Tioga Pines*, 622 N.E.2d at 938-39.

106. (1) A Market Area Limitation (MAL) shall be effective for all providers covered by 470 IAC 5-4.1. The limitation shall be computed on a state-wide basis . . . using projected data submitted by providers for rate reviews. The MAL is an amount which shall be one hundred forty percent (140%) of the

were obtained by the nursing facilities that prevented the Department from using the tests of reasonableness,<sup>107</sup> including the Gross National Product implicit price deflator (GNP/ipd) used in the maximum annual rate increase limiter, and from making line item comparisons without accounting for the facility's size. The Indiana Supreme Court accepted transfer of the consolidated appeal.

The trial court found the rules implementing the tests of reasonableness were not legally promulgated because two members of the State Board of Public Welfare voted by proxy. The supreme court found, however, that the use of the proxies was not harmful error, especially in light of the fact that the nursing facilities waited at least five years from the time of their promulgation before bringing suit.<sup>108</sup>

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average allowable cost, weighted by certified beds, for the same type of providers.

The average allowable cost for each type of provider shall be maintained by the department and a revision shall be made to this rate limitation four (4) times per year effective on March 1, June 1, September 1, and December 1. Providers whose allowable costs are less than the MAL for their type of service may retain a percentage of the difference as an incentive factor for efficient operation. . . .

(2) The calculated rate is the sum of the allowed *per diem* costs and the add-on incentive. The add-on incentive is a percentage of the difference between the MAL and allowable *per diem* cost, if allowable *per diem* cost is less than the MAL. The provider shall be paid at the calculated rate if such a rate does not exceed any of the other limitations outlined herein.

(3) The maximum allowable annual rate increase shall not be greater than the average rate of change, expressed as a decimal, of the most recent twelve (12) quarters of the Gross National Product Implicit Price Deflator. The twelve (12) quarters cited above shall end three (3) months prior to the beginning of the calendar quarter in which a rate is established. . . . The maximum rate allowed by the annual rate increase limitation shall be applicable to any rate established during the twelve (12) month period between annual rate reviews. The maximum rate allowed by the annual rate increase limitation shall be equal to the rate in effect immediately prior to the rate effective date of the annual rate review, times the sum of one, plus the maximum allowable annual rate increase applicable at the rate effective date of the annual rate review.

(4) In no instance shall the approved Medicaid rate be higher than the rate paid to that provider by the general public for the same type of service.

(5) Should the rate calculations produce a rate higher than the reimbursement rate requested by the provider, the approved rate shall be the rate requested by the provider.

IND. ADMIN. CODE tit. 470, r. 5-4.1-9(a) (Supp. 1990).

107. In determining reasonableness of costs, the department may compare line items, major cost centers or total costs of similar providers in the state and may request satisfactory documentation from providers whose cost does not appear to be reasonable. Similar providers are those with like level of care and geographic location.

*Id.* r. 5-4.1-10(d).

108. *Tioga Pines*, 622 N.E.2d at 944.

The trial court also found that the GNP/ipd is unrelated to nursing home care and was impermissibly budget-driven. Although the supreme court found error, it did not provide much support for its determination. The court stated:

There was a percentage annual rate increase limiter atop the Indiana plan before the Boren Amendment. The Boren Amendment standard encourages the State to sharpen its focus upon industry behavior and take steps to encourage more efficient and economical operation within that industry. It encouraged change. The State chose to decrease its longstanding annual rate limiter from 9% to the general rate of inflation, that is between 2.8% and 3.8% during the time applicable here, such limiter to be applied to a cost-driven initial or base rate. The changed plan received federal approval and was applied to the industry for five years before it was challenged in court. . . . [A]nnual increases in Indiana using prior year rates, including the cost-driven initial rate, and consistent with the general rate of inflation, continued to be available. To condemn Indiana's reimbursement system for nursing homes on this basis would be to eviscerate the purpose and intent of Boren and the purpose of Indiana's statute. To do so would merely collapse "the post-Boren language into the pre-Boren reasonable cost standard."<sup>109</sup>

The court added that because the use of the GNP/ipd was not improper, there could be no damages, equitable reimbursement, or retroactive monetary award.<sup>110</sup> Furthermore, because the class did not prevail on its claim that the use of the GNP/ipd is a violation of section 1983 of the Civil Rights Act, the nursing facilities were not entitled to damages under section 1988.<sup>111</sup>

After this decision, the Office of the Secretary of Family and Social Services issued new proposed rules for the rate-setting criteria for nursing facilities.<sup>112</sup> These rules provided that nursing facilities rates are subject to the lowest rate achieved by four limitations: (1) the maximum allowable annual rate increase; (2) rates charged to the general public for the same type of service; (3) the rate requested by the provider; and (4) the allowable per patient day cost.<sup>113</sup> In most other respects the rules were similar to additional rules promulgated but not

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109. *Id.* at 945-46.

110. *Id.* at 946.

111. *Id.* at 947.

112. LSA Document No. 93-188 (adding IND. ADMIN. CODE tit. 405, r. 1-14-1 to 1-14-28).

113. *Id.* at 13-14 (adding IND. ADMIN. CODE tit. 405, r. 1-14-9(a)). The new rules also provide that the maximum allowable rate increase is limited by the average rate of change of the most recent four quarters of the HCFA/SNF index, instead of the average of the last twelve quarts of the increase in the GNP/ipd, that the *per diem* rate can be no greater than the allowable per patient day cost, and that line items, cost centers, and total costs will be compared with like levels of care throughout the state.

implemented by the Department.<sup>114</sup> They have, however, been withdrawn and new proposed rules have not yet been published.<sup>115</sup>

### C. Altering the Method of Medicaid Reimbursement

During the last year, the Office of Medicaid Policy and Planning has proposed drastic changes in the reimbursement methodologies to hospitals and home health agencies under the Indiana Medicaid program. The rules have been challenged by the Indiana Hospital Association (IHA) and litigation is pending in federal district court.<sup>116</sup>

Under the new system, hospitals will be reimbursed for inpatient hospital services provided to Medicaid beneficiaries using a prospective cost-based methodology.<sup>117</sup> The *per diem* rate established using this methodology is not to exceed the established rate for a peer group to which the hospital will be assigned.<sup>118</sup> The peer group rate will be set at 90% of the weighted median of arrayed *per diem* base year costs for facilities in each peer group.<sup>119</sup> Initial rates under the new system will be based on the hospital's inpatient *per diem* fiscal year 1990 allowable costs inflated by the hospital market basket index to the midpoint of the implementation year.<sup>120</sup> The new methodology for the payment of inpatient hospital services is expected to save \$30.1 million in Medicaid expenditures.<sup>121</sup>

Medicaid reimbursement for outpatient hospital services will also be altered to provide for a fee schedule for each procedure or occurrence.<sup>122</sup> These services will be reimbursed at the lower of the actual charge or the fee schedule amount.<sup>123</sup> A maximum allowable payment amount will also be set for services performed by certain practitioners, such as physicians, physical therapists, and oral surgeons.<sup>124</sup> The new methodology for the payment of outpatient hospital services is expected to save \$27.3 million in Medicaid expenditures.<sup>125</sup>

Finally, the Family and Social Services Administration has issued final rules altering the method of payment for home health agencies. These rules provide that home health agencies will be reimbursed for covered services using standard,

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114. See IND. ADMIN. CODE tit. 405 r. 1-4-1 to 1-4-31 (1992).

115. 17 Ind. Reg. 1625 (1994).

116. Indiana Hosp. Ass'n v. Indiana Family & Social Servs. Admin., Cause No. IP94-366C (S.D. Ind. filed Feb. 11, 1994).

117. 17 Ind. Reg. 738, 739 (1994) (adding IND. ADMIN. CODE tit. 405, r. 1-10-3).

118. *Id.*

119. *Id.*

120. *Id.*

121. 16 Ind. Reg. 2704, 2706 (1993) (proposed rules).

122. 17 Ind. Reg. 735, 736 (1994) (adding IND. ADMIN. CODE tit. 405, r. 1-8-2).

123. *Id.* (adding IND. ADMIN. CODE tit. 405, r. 1-8-3).

124. *Id.* at 737 (adding IND. ADMIN. CODE tit. 405, r. 1-11-1, 1-11-2).

125. 16 Ind. Reg. 2701, 2704 (1993) (proposed rules).

statewide rates.<sup>126</sup> Annual rate increases will be limited to the rate of increase for the most recently published HCFA home health agency input price index.<sup>127</sup> These rules have been challenged and litigation is pending in the Delaware Superior Court.<sup>128</sup>

#### *D. Summary of 1993 Indiana Medicaid Law*

The cases decided in the Medicaid area this year create some fairly clear rules, although some room for litigation still exists. The courts have determined that an applicant for Medicaid benefits may spend down his or her resources to meet the Department's eligibility requirements if the applicant meets the SSI eligibility criteria. The courts also denied the claim of Indiana's nursing facilities that the Department's rules fail to provide adequate reimbursement for efficiently operated facilities. The Department must now determine how it will apply the holdings in these cases to provide benefits through the state's Medicaid program in a manner that provides for the equitable distribution of resources within state budgetary constraints. In addition, the Department faces additional legal challenges as it works to provide a reimbursement system for the state's Medicaid program that contains costs. These legal challenges will undoubtedly delay the implementation of any new system, no matter how effective it may be in easing the Medicaid budget problem in this state.

### III. AIDS

In 1993, the Indiana courts were faced with the issue of whether an employer with a self-funded insurance plan may revise the plan to provide limits on the benefits provided for the treatment of acquired immune deficiency syndrome (AIDS). Effective January 1, 1988, Lincoln Foodservice Products, Inc., (Lincoln) revised its self-funded insurance plan to include a \$1,000,000 maximum lifetime benefit for all major medical expenses except expenses for the treatment of AIDS or AIDS-related complex (ARC), which were subject to an annual limit of \$25,000 and a maximum lifetime benefit of \$50,000.

The plaintiff, Kenneth Westhoven, was employed by Lincoln in 1982. He continued to work there until 1989, when he was permanently disabled by AIDS. Mr. Westhoven informed Lincoln in December, 1988, that he tested positive for

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126. 17 Ind. Reg. 1753, 1755 (adding IND. ADMIN. CODE tit. 405, r.1-4.1-4).

127. *Id.*

128. BMH Homecare Servs., Inc. v. Indiana Family & Social Servs. Admin., No. 18D03-9309-CP-166 (Delaware Sup. Ct. filed Sept. 14, 1993) (alleging that the new rate system is illegal because the 1987 rates have no relationship to the actual fees and charges paid in the community for home care services and therefore reimburse providers at levels below their costs in violation of state Medicaid law). See also Eric B. Schoch, *Lawsuit Challenges Medicaid Cutbacks*, INDPLS. STAR, Dec. 29, 1993, at A1.

AIDS. He later sued Lincoln, claiming that Lincoln's plan resulted in unlawful discrimination on the basis of handicap under the Indiana Civil Rights Law (ICRL). The Indiana Civil Rights Commission (ICRC) determined that the plan violated the ICRL and that the ICRL is not preempted by the Employee Retirement Income Security Act (ERISA).<sup>129</sup> The court of appeals disagreed.<sup>130</sup>

The court noted that ERISA preempts "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan."<sup>131</sup> The court added, however, that the scope of preemption is not absolute because ERISA "permits certain independent, albeit potentially inconsistent or contradictory, state action in specified areas of local interest and concern."<sup>132</sup> In addition, plans governed by ERISA are subject to federal laws that impact employee benefit plans.<sup>133</sup>

The court first determined that the Rehabilitation Act of 1973 (Rehabilitation Act)<sup>134</sup> is not preempted by ERISA.<sup>135</sup> Lincoln was not subject to the Rehabilitation Act because it is not a federal contractor. Although the ICRL includes mirror provisions of the Rehabilitation Act that are applicable to private contractors, the provisions of the ICRL are not federal law and do not trigger ERISA preemption.<sup>136</sup>

Next, the court determined that although the Americans with Disabilities Act of 1990 (ADA)<sup>137</sup> prohibits discrimination on the basis of handicap, Lincoln was not bound by the ADA at the time it revised its health insurance plan.<sup>138</sup> Therefore, the court concluded, ERISA preempts the ICRL, and the ICRC did not have jurisdiction to act on Mr. Westhoven's discrimination claim.<sup>139</sup>

Because the ADA is applicable to similar actions by employers today, a plaintiff will be more likely to prevail on a similar claim. The ADA prevents discrimination in "employee compensation . . . and other terms, conditions, and privileges of employment."<sup>140</sup> The ADA does not, however, prohibit insurers

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129. Further detail concerning the ICRC's decision can be found in Vaneeta M. Kumar & Eleanor D. Kinney, *Indiana Lawmakers Face National Health Policy Issues*, 25 IND. L. REV. 1271, 1281-85 (1992).

130. *Westhoven v. Lincoln Foodservice Products, Inc.*, 616 N.E.2d 778, 780 (Ind. Ct. App. 1993).

131. *Id.* at 781 (quoting 29 U.S.C. § 1144(a)).

132. *Id.*

133. *Id.* at 782.

134. 29 U.S.C.A. §§ 701-797b (1985 & Supp. 1993).

135. *Westhoven*, 616 N.E.2d at 783.

136. *Id.*

137. 42 U.S.C. §§ 12101-12213 (Supp. 1993).

138. *Westhoven*, 616 N.E.2d at 784.

139. *Id.* Cf. *McGann v. H & H Music Co.*, 946 F.2d 401 (5th Cir. 1991) (decrease in benefit for the treatment of AIDS did not result in impermissible discrimination under ERISA), *cert. denied sub nom. Greenberg v. H & H Music Co.*, 113 S. Ct. 482 (1992).

140. 42 U.S.C.A. § 12112(a) (West Supp. 1993).

from classifying risks or administering the terms of a bona fide employee benefit plan.<sup>141</sup> If, however, an employer alters a self-funded plan for reasons other than business necessity, that employer may be found to have violated the provisions of the ADA. Therefore, the holding of the *Westhoven* decision should not be applied as a bright line rule in determining whether an employer has engaged in illegal conduct by altering the terms of an employee benefit plan.

#### IV. PEER REVIEW AND MEDICAL STAFF RELATIONS

Two cases of interest were decided this year that involve the discipline of physicians by a hospital peer review committee. These cases involve the concept of intracorporate immunity and the composition of peer review committees reviewing the actions of physicians in hospitals.

##### A. *Intracorporate Immunity*

This year, the Seventh Circuit Court of Appeals adopted the doctrine of intracorporate immunity for the actions of a hospital in the peer review process.<sup>142</sup> After his medical staff privileges were terminated, Dr. Joseph Pudlo brought an antitrust claim under Section One and Section Two of the Sherman Act against Resurrection Medical Center, ten internists who were in competition with him, the Medical Center's Executive Committee, its Chief Executive Officer, and members of the governing board. During the peer review process, the Medical Center's Executive Committee, which consisted of members of the medical staff, recommended that Dr. Pudlo's privileges not be terminated. Its governing board rejected the recommendation and terminated Dr. Pudlo's medical staff appointment.

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141. Subchapters I through III of this chapter and title IV of this Act shall not be construed to prohibit or restrict—

(1) an insurer, hospital or medical service company, health maintenance organization, or any agent, or entity that administers benefit plans, or similar organizations from underwriting risks, classifying risks, or administering such risks that are based on or not inconsistent with State law; or

(2) a person or organization covered by this chapter from establishing, sponsoring, observing or administering the terms of a bona fide benefit plan that are based on underwriting risks, classifying risks, or administering such risks that are based on or not inconsistent with State law; or

(3) a person or organization covered by this chapter from establishing, sponsoring, observing or administering the terms of a bona fide benefit plan that is not subject to State laws that regulate insurance.

Paragraphs (1), (2), and (3) shall not be used as a subterfuge to evade the purposes of subchapters I and III of this chapter.

*Id.* § 12201(c).

142. *Pudlo v. Adamski*, 2 F.3d 1153 (7th Cir. 1993), *petition for cert. filed*, 62 U.S.L.W. 3350 (U.S. Nov. 4, 1993).

The District Court for the Northern District of Illinois rejected Dr. Pudlo's claims based on its acceptance of the intracorporate immunity doctrine articulated in *Copperweld Corp. v. Independence Tube Corp.*<sup>143</sup> The court noted that the Medical Center's governing board delegated peer review decision-making authority to its medical staff, making its medical staff an integral component of the Medical Center's management structure.<sup>144</sup> Therefore, the medical staff acted as an officer of the corporation.<sup>145</sup>

The court also reasoned that, although the individual members of the medical staff were competitors and were capable of conspiring among themselves, the governing board retained ultimate authority over the decision to revoke Dr. Pudlo's privileges.<sup>146</sup> Therefore, the medical staff's actions could not have resulted in antitrust injury to the physician.<sup>147</sup> In addition, because the Medical Center lacked the capacity to conspire with its medical staff under the doctrine of intracorporate immunity for purposes of Section One of the Sherman Act, it could not conspire with the medical staff for purposes of Section Two.<sup>148</sup>

On appeal, the Seventh Circuit adopted the district court's opinion and stated that it was adopting the position that under the doctrine of intracorporate immunity, a hospital is legally incapable of conspiring with its medical staff in the peer review process when the medical staff acts through the delegation of authority by the hospital's governing board.<sup>149</sup>

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143. *Pudlo v. Adamski*, 789 F. Supp. 247, 250-52 (N.D. Ill. 1992) (citing *Copperweld Corp. v. Independence Tube Corp.*, 467 U.S. 752 (1984)), *aff'd*, 2 F.3d 1153 (7th Cir. 1993), *cert. denied*, 114 S. Ct. 879 (1994). The court noted that *Copperweld* is "widely cited" for the following propositions:

(1) an agreement between a parent corporation and its wholly-owned subsidiary is not a concerted action for purposes of Section 1; (2) an agreement between officers or employees of the same firm does not ordinarily constitute a Section 1 conspiracy; and (3) a corporation is legally incapable of conspiring with its agents or employees.

*Id.*

144. *Id.* at 251.

145. *Id.*

146. *Id.*

147. *Id.* at 252.

148. *Pudlo*, 789 F. Supp. at 252.

149. *Pudlo*, 2 F.3d at 1154. See also *Okansen v. Page Mem. Hosp.*, 945 F.2d 696 (4th Cir. 1991) (applying the doctrine of intracorporate immunity to an alleged conspiracy between a hospital and members of its medical staff, but recognizing that members of the medical staff could conspire among themselves), *cert. denied*, 112 S. Ct. 973 (1992); *Nanavanti v. Burdette Tomlin Mem. Hosp.*, 857 F.2d 96, 118 (3d Cir. 1988) (hospital cannot conspire with executive committee); *Weiss v. York Hosp.*, 745 F.2d 786, 814-15 (3d Cir. 1984) (a hospital cannot conspire with its medical staff; however, individual doctors on the medical staff may form a conspiracy), *cert. denied*, 470 U.S. 1060 (1985). But see *Bolt v. Halifax Medical Ctr.*, 891 F.2d 810, 819 (11th Cir. 1990) ("we hold that a hospital and the members of its medical staff are all legally capable of conspiring with one another"), *cert. denied*, 495 U.S. 924 (1990).

### B. Committee Composition

In *Mann v. Johnson Memorial Hospital*,<sup>150</sup> the Indiana Court of Appeals held that the Johnson Memorial Hospital Bylaws, which allowed members of the Board of Trustees and hospital administration to sit on an *ad hoc* committee formed to review the actions of physicians, did not comply with the Indiana peer review statute.<sup>151</sup> The hospital's Board of Trustees brought charges against Dr. Michael Mann seeking to terminate his clinical privileges. An *ad hoc* committee was appointed to hear the evidence against Dr. Mann. Dr. Mann unsuccessfully sought to enjoin the committee's proceedings.

The hospital's bylaws contained the following provisions:

Whenever the professional review action could lead to a reduction or suspension of clinical privileges for a member, the Board of Trustees in its discretion, may . . . (3) appoint an Ad Hoc Hearing Committee as provided in Section 4.5 and proceed directly to a hearing as provided in Article IV.

. . . .  
The Ad Hoc Hearing Committee may include . . . members of the Board of Trustees, . . . Hospital Administration, . . . members of the Medical Staff . . . practitioners who are not members of the Medical Staff. . . .<sup>152</sup>

Dr. Mann argued that these provisions were in violation of the requirement in the Indiana peer review statute that a professional health care provider in a hospital is entitled to an evidentiary hearing "before a peer review committee of the medical staff."<sup>153</sup> The court of appeals agreed.<sup>154</sup>

The court noted that, even if the hospital's bylaws conformed to the requirements of the Health Care Quality Improvement Act of 1986,<sup>155</sup> they must also conform to any additional procedural safeguards provided by state

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150. 611 N.E.2d 676 (Ind. Ct. App. 1993).

151. *Id.* at 679.

152. *Id.* at 677.

153. *Id.*

(e) However, if charges are brought against a professional health care provider in a hospital that, if sustained by the governing board of the hospital, could result in an action against a physician required to be reported to the medical licensing board . . . or a similar disciplinary action against any other health care provider, the professional health care provider is entitled to one (1) evidentiary hearing before a peer review committee of the medical staff and one (1) additional hearing on appeal before the governing board of the hospital.

IND. CODE § 34-4-12.6-2(e) (1993).

154. *Mann*, 611 N.E.2d at 679.

155. 42 U.S.C.A. §§ 11101-11052 (Supp. 1993).

law.<sup>156</sup> The court then declared that it would "follow the plain language of the statute" and declared the bylaws to be unlawful.<sup>157</sup>

### C. Summary of 1993 Peer Review Cases

Taken together, these two decisions provide that a physician practicing in a hospital is entitled to one hearing before a peer review committee composed entirely of members of the medical staff. If, however, the governing board delegates its authority to such a committee, the actions of the committee will be protected under the Indiana peer review statute and the hospital's actions will be protected from challenge under the antitrust laws under the doctrine of intracorporate immunity.

## V. RECENT FEDERAL DEVELOPMENTS

The previous sections of this Article outline rules that govern the actions of health care providers within our current health care system. It is important to keep these rules in mind as the nation moves toward a restructuring of our entire health care system that promises to provide a special role for the states. Unfortunately, the scope of this Survey does not permit an in-depth discussion of the various proposals for nationwide change. However, a few changes have been made that, when considered in conjunction with these proposals, may act to place limits on the actions of providers as they scramble to form networks and integrated delivery systems to prepare for a system of managed competition. This section of the Article provides a brief description of these changes.

### A. The Anti-Referral Provisions of OBRA '93

The Omnibus Budget Reconciliation Act of 1993 (OBRA '93),<sup>158</sup> which was passed in August, includes provisions that extend the anti-referral provisions of the Stark Act.<sup>159</sup> Under the Stark Act, physicians are prohibited from referring patients for clinical laboratory services to any entity in which the physician or a member of the physician's immediate family has a financial interest and prohibits entities accepting such referrals from billing for the services rendered as a result of the referral.<sup>160</sup> The prohibition against the referral of patients now extends to entities providing "designated health services." The designated health services covered by OBRA '93 include clinical laboratory services; physical and occupational therapy services; radiology and other diagnostic services; radiation therapy services; durable medical equipment;

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156. *Mann*, 611 N.E.2d at 678.

157. *Id.* at 678-79.

158. Omnibus Budget Reconciliation Act of 1993, Pub. L. No. 103-66, § 13562(a)(1) (to be codified at 42 U.S.C. § 1395nn).

159. 42 U.S.C.A. § 1395nn (Supp. 1993). These provisions are also known as "Stark II."

160. *Id.* § 1395nn(a).

parenteral and enteral nutrients, equipment, and supplies; prosthetics, orthotics, and prosthetic devices; home health services; outpatient prescription drugs; and inpatient and outpatient hospital services.<sup>161</sup>

The ownership interests that will cause a physician to be subject to the anti-referral provisions include any ownership or investment interest in or compensation arrangement with an entity that provides designated health services.<sup>162</sup> An ownership or investment interest includes any equity, debt, or other financial interest as well as any interest in an entity that holds an ownership or investment interest in an entity providing designated health services.<sup>163</sup> Exceptions for certain ownership interests are provided, including ownership of publicly traded securities, ownership interests in certain entities in rural areas, and investment interests in hospitals if the interest is not in a subdivision of the hospital.<sup>164</sup>

The compensation arrangements covered by OBRA '93 include any arrangement involving remuneration between a physician or a member of the physician's immediate family and an entity providing designated health services. The types of remuneration covered include any remuneration "directly or indirectly, overtly or covertly, in cash or in kind."<sup>165</sup> OBRA '93 also provides exceptions for certain financial arrangements, including the rental of office space, equipment rental, compensation to an employee, personal services arrangements, physician incentive plans, remuneration unrelated to the provision of designated health services, physician recruitment arrangements, isolated transactions, group practice arrangements with hospitals, and payments by physicians for items or services.<sup>166</sup> Three general exceptions are also provided, including exceptions for services provided personally by another member of the physician's practice group, certain in-office ancillary services, and services provided by certain prepaid plans.<sup>167</sup>

### *B. The Proposed Safe Harbors*

On September 21, 1993, the Office of the Inspector General issued proposed rules for an additional seven safe harbors that will provide protection from civil and criminal liability under the Medicare-Medicaid Anti-Kickback Statute.<sup>168</sup> The anti-kickback statute provides that anyone who knowingly solicits, receives,

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161. Omnibus Budget Reconciliation Act of 1993, Pub. L. No. 103-66, § 13562(a)(1) (to be codified at 42 U.S.C. § 1395nn(h)(6)).

162. *Id.* § 13562(a)(1).

163. *Id.*

164. *Id.* § 13562(c), (d).

165. *Id.* § 13562 (to be codified at 42 U.S.C. § 1395nn(h)(1)(B)).

166. *Id.* § 13562 (to be codified at 42 U.S.C. § 1395nn(e)).

167. *Id.* § 13562 (to be codified at 42 U.S.C. § 1395nn(b)).

168. Health Care Programs: Fraud and Abuse; Additional Safe Harbor Provisions Under the OIG Anti-Kickback Statute, 58 Fed. Reg. 49008 (1993).

offers, or pays any remuneration for the referral of an individual for the furnishing or arranging of any item or service payable by Medicare or Medicaid or who purchases, leases, orders, arranges for, or recommends purchasing, leasing, or ordering any good, service, or item payable by Medicare or Medicaid commits a felony and may be subject to imprisonment, fines, civil monetary penalties, and exclusion from the Medicare and Medicaid programs.<sup>169</sup>

Currently, eleven safe harbors have been promulgated that provide immunity from civil and criminal liability under the anti-kickback statute.<sup>170</sup> However, these safe harbors are not easily applied and provide protection for only a very narrow segment of the activities in which health care providers engage.

The proposed safe harbors include immunity under certain circumstances for investment interests in rural areas, ambulatory surgical centers, and group practices composed of active investors; practitioner recruitment by rural hospitals; obstetrical malpractice payment subsidies; referral agreements for specialty services; and cooperative hospital service organizations.<sup>171</sup> Unfortunately, these safe harbors do not provide much protection for health care providers outside rural areas. Because of their limited utility, it is unlikely that practitioners will feel any increased sense of comfort in determining whether their behavior falls within the confines of a statute that encompasses a number of activities.

### C. *The Medicare Anti-Dumping Statute*

This year, the Seventh Circuit Court of Appeals sought to extend the limits of the Emergency Treatment and Active Labor Act (EMTLA), which is also known as the Medicare "anti-dumping" statute,<sup>172</sup> by including within its purview triage activities that are performed before a patient arrives in the emergency department. On February 2, 1990, a one-year-old infant in respiratory arrest was transported by paramedics who contacted a telemetry operator at the University of Chicago Hospital. The hospital redirected the ambulance to St. Bernard's Hospital because the University of Chicago Hospital pediatric intensive care unit was on partial bypass. After emergency treatment, the infant was transferred to Cook County Hospital because St. Bernard's Hospital did not have a pediatric intensive care unit in which to treat her. The infant's mother brought an action against the University of Chicago Hospital, claiming various common law torts and a violation of the anti-dumping statute.

The District Court for the Northern District of Illinois granted the defendant's motion to dismiss. The Seventh Circuit Court of Appeals originally reversed, agreeing with the argument made by the infant's mother that the anti-dumping

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169. See 42 U.S.C.A. § 1320a-7b(b) (West Supp. 1993).

170. 42 C.F.R. § 1101.952 (1993).

171. Health Care Programs: Fraud and Abuse; Additional Safe Harbor Provisions Under the OIG Anti-Kickback Statute, 58 Fed. Reg. 49008 (1993).

172. 42 U.S.C.A. § 1395dd (West 1992).

statute applies when a hospital has been informed of a patient's medical condition, even though the patient has not "come to" the hospital's emergency department.<sup>173</sup> The Seventh Circuit later vacated its decision, holding that the infant never "came to" the emergency department and therefore, the University of Chicago Hospital's actions in providing instructions through its telemetry service were not actionable under the anti-dumping statute.<sup>174</sup> Therefore, for the anti-dumping statute to apply, a patient must be refused stabilizing treatment at or after the time the patient presents himself in the emergency department.

## VI. CONCLUSION

This Article describes only a few of the changes which are driving the health care system in Indiana. Undoubtedly, as our nation moves toward a more unified system of health services delivery, further changes in the laws, rules, and decisions affecting health care lawyers, health care providers, and patients will be made in a very short period of time. Only after further debate will the legislature and the courts find the best solutions to the multitude of problems facing our health care system today. In 1994, health care lawyers should keep their eye toward national changes and the role of the states in implementing those changes. Hopefully, even better solutions are near at hand.

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173. *Johnson v. University of Chicago Hosps.*, 774 F. Supp. 510 (N.D. Ill. 1991), *aff'd in part, rev'd in part*, 982 F.2d 230 (7th Cir. 1993) (per curiam).

174. *Johnson*, 982 F.2d at 233.

