STATE OF TEXAS · 90TH LEGISLATURE · REGULAR SESSION

Texas Physician Independence and Patient Protection Act

A Bill to be Entitled an Act relating to the protection of the physician-patient relationship and the independent professional judgment of physicians

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Working draft, Revision 5

November 2, 2026

Prepared by a Texas emergency physician

Not a Texas Legislative Council document. Not legal advice.

Drafter’s note

This bill puts Texas’s century-old corporate practice of medicine doctrine into a single statutory chapter and closes every door through which a person who does not hold a medical license has come to control the people who do: management services organizations (MSOs) fronted by a “friendly physician,” private-equity contract management groups holding hospital coverage contracts, corporate-appointed medical directors with no standing among the physicians they direct, volume quotas that trade patient time for budget, and noncompetes that keep physicians from leaving. It does not ban MSOs or outside capital. It requires that the physicians who hold the license and carry the liability hold the decisions and the professional fees.

Revision 2 (evening of November 2, 2026) added, at the author’s direction: Sec. 166.055 (physician-versus-nonphysician staffing is a reserved clinical decision; no volume quotas; physician physically present in every emergency department); Sec. 166.056 (medical directors must be experienced in the specialty, actively practicing at the site, and selected and removable by the physicians they direct); Sec. 166.107 (professional fees belong to the physicians who earn them; nobody profits off a license they do not hold); Subchapter H (hospitals, freestanding emergency facilities, and surgery centers may obtain physician services only from physicians or practices wholly owned by physicians, never from an MSO or staffing company); and a rewritten Sec. 166.151 that voids physician noncompetes outright. Note on that last point: physician noncompetes are lawful in Texas today under Section 15.50(b), Business and Commerce Code, as narrowed by SB 1318 (89R, 2025) to one year, five miles, and a buyout capped at one year’s pay. This bill does not declare them already illegal; it makes them void going forward and amends Section 15.50 to match.

Revision 3 (late evening, November 2, 2026) added Sec. 166.058 at the author’s direction: any Texas-licensed physician may staff an emergency department subject to individual credentialing; no facility, practice, staffing company, or payor may require emergency medicine board certification as a condition of ED work or exclude a physician for being certified in family medicine, internal medicine, or another specialty; and no one may pay a physician less per hour, shift, or encounter for the same ED work on the basis of specialty certification. The medical-director qualification in Sec. 166.056(b) was amended to match, so an FM or IM physician with five years of ED practice can direct an ED.

Revision 3 also added Sec. 166.257: an executive who knowingly adopts or enforces a policy that controls a decision reserved to physicians is practicing medicine without a license under existing Section 165.152 (a third-degree felony); if the policy is a proximate cause of bodily injury to a patient the offense is a second-degree felony, and if it causes a death, a first-degree felony. The organization is criminally responsible with the officer and loses the right to manage practices or contract with facilities for 10 years. Two honest notes for the sponsor: criminal sections draw the

hardest constitutional scrutiny, so the “knowingly” standard and the proximate-cause element are load-bearing and should not be softened into strict liability; and the attorney general cannot prosecute on his own in Texas (the Court of Criminal Appeals settled that in 2021), so the section routes prosecution through the local district or county attorney with AG assistance.

Revision 4 (just before midnight, November 2, 2026) added, at the author’s direction: Sec. 166.059 (a physician’s right to decline a surgery, procedure, or treatment the physician judges unsafe or not indicated; broad definition of “adverse action”; one-year presumption of retaliation rebuttable only by clear and convincing evidence after a same-specialty medical staff hearing; retaliatory peer review stripped of state-law peer-review privilege and immunity; governing body may act on privileges only on medical staff recommendation or license, exclusion, or criminal grounds; economic credentialing barred; mandatory TRO restoring privileges, bond capped at $1,000; Data Bank reports from retaliation voided); Sec. 166.257(b-1) (an officer who retaliates for a refusal, or orders the declined procedure done by someone else, commits the offense, with the harm grades applying if a patient is injured or dies as a result); Sec. 166.356 (no executive incentive compensation tied to physician productivity, staffing cuts, nonphysician ratios, subsidy reduction, or billing intensity; no indirect pressure through contracts, rebids, or subsidies; annual public filing of executive incentive metrics with HHSC and the medical executive committee; clawback; whistleblower protection); and Sec. 166.252(e) (15 to 30 percent award to a whistleblower whose original information leads to an AG recovery). Drafting note on 166.059(e): HCQIA immunity is federal and a state statute cannot strip it, so the subsection removes only the state-law peer-review privilege and immunity and, for the federal immunity, places the burden on the claimant to prove the action met 42 U.S.C. 11112(a), which a retaliatory action does not.

Revision 4, continued: Sec. 166.356(d) was rewritten from an objection right into a ratification requirement. Each year the governing body must put the executive incentive plan (every metric, definition, and weight) to the active medical staff for a secret-ballot vote; a plan the physicians do not ratify is void and no bonus may be paid under it; the plan, the vote, and the bonuses actually paid are filed with HHSC and published; retaliation for the vote is an adverse action under Sec. 166.059; and the medical executive committee may sue to enjoin and recover a bonus paid without ratification. The subsection carries its own finding: facility revenue is generated under physicians’ licenses, and the physicians are entitled to approve how it is paid out as incentives to people who hold none. Drafting note: this is the provision the Texas Hospital Association will call a governance takeover. The answer is that it governs one thing only, the executive bonus plan, and that CMS Conditions of Participation already require the governing body to consult the medical staff on major decisions; this makes one of those consultations a vote.

Revision 4, continued: closed the nonprofit health organization (“501(a)”) route. Section 162.001 lets TMB-certified nonprofit health organizations employ physicians, and every hospital system and most large groups in Texas run their employed physicians through one; on paper a physician board controls it, in practice the hospital or an MSO funds and manages it. As first drafted,

Subchapter G exempted those organizations from the MSO rules and the professional-fees rule, and Subchapter H allowed facility staffing through them, which together would have let a hospital route an entire emergency department through its 501(a) and keep the fees. New Sec. 166.302 limits the exemption to the organization's own employment relationship; subjects every agreement between a 501(a) and an MSO, staffing company, or investor to Subchapter C; requires a 501(a) that serves a facility or is funded or managed by anyone other than its physicians to have a board majority elected by its employed physicians, to hold its own professional fees, to set physician compensation and productivity standards only by physician vote, and to file its funding and management agreements with TMB; applies the de facto control test to 501(a)s without regard to their certificate; makes using any nonprofit, tax-exempt, or physician-owned entity as a conduit a violation; and requires TMB to revoke certification on a finding of evasion, after which a facility staffing through that organization violates Sec. 166.351. Section 4 of the Act was expanded to amend Sec. 162.001 to match and to require TMB compliance review every two years.

Revision 5 (early morning, November 3, 2026) applied the red-team fixes from the companion document "T-PIPPA Red Team — Holes, Loopholes, and Fixes": control now counts nonvoting, convertible, and synthetic equity at 10 percent and carries a regulated-lender safe harbor (166.001(3)); staffing-company definition excludes flat-fee placement agencies and Subchapter H allows locums up to 180 days a year (166.001(2), 166.351(a)(5)); restrictive covenant includes repayment clauses, forfeitures, tail-coverage liability, notice periods over 90 days, and automatic loss of privileges, all void under 166.151(a), with a two-year amortized signing-bonus exception; physician-owned entities may include out-of-state physicians if Texas physicians hold the majority (166.001(17), 166.106); choice-of-law and forum provisions cannot avoid the chapter (166.002(d)); physician-committee protocols and co-management agreements are safe-harbored (166.051(b), 166.356(g)); coding scorecards and repeated queries are control, not assistance (166.053); MSOs may not hold liens on fees or records, pay the practice's physician-owner more than a disclosed FMV administrative fee capped at 25 percent of his income, or be insurer-affiliated (166.103(14) to (16)); aggregate MSO payments above 40 percent of net collections are presumed not FMV (166.104(c)); non-bank loans must be unsecured and capped (166.107(b)(3)); the grandfather ends on any 10 percent transfer or any refinancing, amendment, or renewal (Sec. 7(b)(2)); qui tam enforcement with a 25 to 30 percent relator share (166.252(f)); claims are not Chapter 74 health care liability claims, medical staffs and physician associations have standing, statutory damages of $25,000 per violation, and fees collected during suit are escrowed (166.253); the criminal section defines harm terms and the scienter the state must prove (166.257(c-1)) and prosecutors' inaction is published (166.257(j)); system-level CMOs are outside the medical-director rules (166.056(g)); trauma rules are preserved but may not gatekeep by specialty alone (166.058(c)(3)); privileges continue 180 days after a contract ends (166.059(g)); the retaliation window is one year throughout (166.153(c)); hospital districts and governmental hospitals are covered with immunity waived for equitable relief, reinstatement, and back pay (166.301(3)); the owner of a contracting practice may not be a facility employee or officer (166.352(b)(5)); TMB

fees are scaled and dedicated (166.201(c)); the patient notice is limited to factual ownership statements (166.202); and the caption now says “creating criminal offenses.” Remaining for TLC: move “adverse action” and “responsible officer” references to the new definitions in 166.001(18) and (19), reletter 166.257(b-1) and (c-1), renumber Section 6A, and confirm Sec. 104.004 and Subchapter E, Chapter 311, Health and Safety Code.

Where it fits: Texas has no section headed “corporate practice of medicine.” The doctrine is assembled from the Medical Practice Act (Occupations Code, Title 3, Subtitle B), the Business Organizations Code (who may own a professional entity), and a thin line of case law. This bill adds a new Chapter 166 to Subtitle B of Title 3 so the rules sit next to the Medical Practice Act and fall under the Texas Medical Board’s existing enforcement machinery.

Sources borrowed from, by design:

- HB 2982 (88R, 2023, Oliverson) — a Texas-drafted MSO bill that never got a hearing. Its permitted-services list and prohibited-acts list are reused here almost verbatim because they already use Texas Legislative Council drafting style.
- Oregon SB 951 (2025), now law — the ownership, equity-control, financial-act, dual-role, and restrictive-covenant provisions, plus the tiered transition period.
- Texas SB 613 (89R, 2025, Hinojosa) — the veterinary private-equity bill, for the Texas-style “void contract” language.

What a sponsor’s office will need to do before filing:

1. Run it through Texas Legislative Council for a bill number, drafting-style conformance, and a check of every cross-reference (Section 3 cites existing Occupations Code and Business Organizations Code sections by number; TLC will verify each).
2. Decide the exemption list (Subchapter G). The draft exempts licensed hospitals and hospital-owned clinics, which is politically necessary but is also the single biggest hole; see the appendix.
3. Pick the transition dates. The draft uses September 1, 2027 for new arrangements and September 1, 2030 for existing ones, mirroring Oregon’s three-year runway.
4. Pre-filing opens November 9, 2026; session convenes January 12, 2027; the bill-filing deadline is March 12, 2027.

This is a working draft prepared by a physician, not a Texas Legislative Council product and not legal advice.

CAPTION AND ENACTING CLAUSE

By: _____ S.B. No. _____

A BILL TO BE ENTITLED

AN ACT

relating to the protection of the physician-patient relationship and the independent professional judgment of physicians; regulating management services organizations, medical directors, nonprofit health organizations, and other persons that provide services to, contract with, or hold interests in physician practices; regulating contracts for physician services and executive incentive compensation at hospitals and certain other health facilities; prohibiting certain covenants not to compete; providing civil and administrative penalties; creating criminal offenses; authorizing civil actions and a fee.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

SECTION 1. SHORT TITLE

SECTION 1. SHORT TITLE. This Act may be cited as the Texas Physician Independence and Patient Protection Act.

SECTION 2. LEGISLATIVE FINDINGS AND PURPOSE

SECTION 2. FINDINGS AND PURPOSE. (a) The legislature finds that:

1. The practice of medicine in this state has been reserved by law to individuals licensed by the Texas Medical Board for more than a century, and this state has long prohibited a corporation or other lay entity from practicing medicine, employing a physician to practice medicine, or interposing itself between a physician and a patient.
2. The purpose of that prohibition is to ensure that decisions about the diagnosis and treatment of a patient are made by a licensed physician whose sole loyalty is to the patient, free from the influence of a person whose primary obligation is to shareholders, investors, or creditors. The physician, not the investor, holds the license, takes the oath, and bears the legal and professional responsibility for the patient’s outcome.
3. In recent years, lay investors, including private equity funds and publicly traded corporations, have acquired effective ownership and control of physician practices in this state through management services agreements, stock transfer restriction agreements, continuity or succession agreements, and similar arrangements under which a licensed physician holds nominal title to the practice while the investor controls hiring, compensation, scheduling, staffing, billing, coding, patient volume, and the sale of the practice.
4. The same investors have acquired the contracts under which hospitals obtain emergency, anesthesia, hospitalist, radiology, and other physician coverage, so that physicians who treat

patients in Texas hospitals answer to a staffing company and its lenders rather than to the hospital's medical staff or to the patients they serve. Private equity-backed staffing companies hold the physician coverage contracts at roughly one quarter of emergency departments nationally, and two of the largest have entered bankruptcy since 2023.

5. These arrangements evade the prohibition on the corporate practice of medicine in form while defeating it in substance. They have been associated with volume and productivity quotas that reduce the time a physician may spend with a patient, pressure to increase billing intensity, the replacement of physician coverage with less-trained personnel to reduce cost, understaffing, the loss of independent practices in rural and underserved communities, and the use of noncompetition and nondisclosure agreements that prevent physicians from leaving or from speaking about conditions that endanger patients.
6. Physicians are increasingly directed by medical directors who are appointed by the investor or facility rather than chosen by the physicians they supervise, who may lack experience in the specialty they direct or active practice at the site, and whose continued appointment depends on carrying out the investor's financial objectives rather than the medical staff's clinical judgment.
7. When the professional fees generated by a physician's license are diverted to persons who do not hold a license and bear no professional liability, the physician is left to meet an investor's budget by seeing more patients in less time, and patients bear the cost in missed diagnoses, rushed care, and avoidable harm.
8. Physicians certified in family medicine, internal medicine, and other specialties have staffed Texas emergency departments for decades and provide most of the emergency physician coverage in rural and community hospitals, where emergency medicine-certified physicians are few. Staffing companies and facilities nonetheless exclude these physicians from emergency departments, or pay them less per hour, shift, or encounter than emergency medicine-certified physicians for identical work, on the basis of specialty certification rather than individual training, experience, and competence. That practice reduces access to emergency care, drives experienced physicians out of emergency departments, and devalues the physician's license and labor.
9. This state licenses physicians, not specialties. A physician's license authorizes the practice of medicine in every branch, and the regulation of discrimination among the state's own licensees on the basis of specialty certification is an exercise of the state's authority over the license it issues.
10. No existing provision of state law clearly defines the boundary between permitted administrative support of a physician practice and prohibited control of that practice, and the Texas Medical Board lacks express authority to examine and act on the arrangements through which that control is exercised.

b. The purpose of this Act is to:

1. codify the prohibition on the corporate practice of medicine in a single chapter of the Occupations Code;
2. define the administrative and business services that a management services organization may lawfully provide to a physician practice;
3. reserve to physicians the clinical, professional, staffing, and practice-governance decisions on which the physician-patient relationship depends, including the decision whether a patient is treated by a physician or by a person acting under physician delegation;
4. require that a physician who directs other physicians be qualified in their work, actively practicing alongside them, and accountable to them;
5. ensure that a physician's eligibility and compensation for emergency department work rest on the physician's individual training, experience, and competence and not on the specialty in which the physician is certified;
6. prohibit arrangements by which a person who is not a physician obtains ownership or control of a physician practice in substance;
7. ensure that the professional fees earned under a physician's license are retained by the physicians who hold that license and bear that liability, so that a physician is not forced to compromise patient care to meet a budget set by others;
8. require that hospitals and other licensed facilities obtain physician services directly from physicians or from practices wholly owned by physicians;
9. void covenants not to compete and gag provisions that are used to bind physicians to those arrangements; and
10. provide effective enforcement through the Texas Medical Board, the Health and Human Services Commission, the attorney general, and the courts.

SECTION 3. NEW CHAPTER 166, OCCUPATIONS CODE — SUBCHAPTER A, DEFINITIONS

SECTION 3. Subtitle B, Title 3, Occupations Code, is amended by adding Chapter 166 to read as follows:

CHAPTER 166. PROTECTION OF THE PHYSICIAN-PATIENT RELATIONSHIP; MANAGEMENT SERVICES ORGANIZATIONS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 166.001. DEFINITIONS. In this chapter:

1. "Board" means the Texas Medical Board.

2. “Contract management group” or “staffing company” means a person, other than a physician practice wholly owned by physicians, that contracts with a facility to provide, arrange, schedule, or manage physician services at the facility, or that employs or engages physicians for that purpose, regardless of whether the person does so directly or through a physician practice it manages or controls. The term does not include a placement agency that locates an individual physician for a facility or physician practice for a fixed placement fee, holds no contract to provide or manage coverage of a department or service, and exercises no control over the physician’s clinical work, compensation, or schedule beyond the dates of the placement.
3. “Control” means the possession, directly or indirectly, through ownership of any interest, by contract, by proxy, by a right of first refusal or similar restriction, by a security interest or default right, or otherwise, of the power to direct or cause the direction of a decision described by Section 166.051, 166.052, or 166.055, regardless of whether that power is exercised. A person is presumed to have control if the person holds, individually or together with affiliates, 10 percent or more of the equity, economic, or profits interest of any class in a physician practice or management services organization, voting or nonvoting, counting convertible instruments, warrants, options, phantom or synthetic equity, and earn-outs as if exercised or converted, or has the power to designate or remove a majority of the governing body of a physician practice. Control does not include the rights of a financial institution regulated under Title 3, Finance Code, or a bank regulated by a federal banking agency, under a loan made in the ordinary course of business that is not convertible into equity, carries no warrant, option, or profits interest, and whose covenants concern only the borrower’s financial condition and not any decision reserved to physicians by Subchapter B.
4. “De facto control” means control in substance over a physician practice held by a person who is not a physician, however documented or undocumented, including control exercised through a management services agreement, a stock transfer restriction agreement, a continuity or succession agreement, a promissory note or security interest, an option, a voting trust, a proxy, or an arrangement under which the nominal physician owner may be removed or replaced at the direction of a person who is not a physician.
5. “Facility” means a hospital licensed under Chapter 241, Health and Safety Code, a freestanding emergency medical care facility licensed under Chapter 254, Health and Safety Code, an ambulatory surgical center licensed under Chapter 243, Health and Safety Code, and a hospital or facility owned or operated by a hospital district or other governmental entity.
6. “Management services” means administrative or business services provided to a physician practice under a written agreement for compensation, including payroll, human resources, employment screening, employee relations, facilities, equipment, information technology,

billing and collection, accounting, purchasing, marketing, and contract administration, that support but do not constitute the practice of medicine.

7. “Management services agreement” means a written agreement, however titled, under which a management services organization provides management services to a physician practice.
8. “Management services organization” or “MSO” means a person that, under a written agreement and for compensation, provides management services to a physician practice. The term does not include a facility with respect to a physician practice it is authorized to own under Section 162.001 or Chapter 844, Insurance Code, or a physician practice that provides management services to another physician practice and is wholly owned by physicians.
9. “Medical director” means a physician who is designated by any person to supervise, direct, evaluate, schedule, or set policy for other physicians who provide clinical services at a facility, department, service line, or practice location, by whatever title the physician is known.
10. “MSO agent” means an owner, member, partner, shareholder, director, manager, officer, employee, or independent contractor of a management services organization, and any affiliate of the organization.
11. “Nonphysician practitioner” means a physician assistant licensed under Chapter 204, an advanced practice registered nurse as defined by Section 301.152, or another person who provides clinical services under the delegation or supervision of a physician.
12. “Physician” means an individual licensed to practice medicine in this state under this subtitle.
13. “Physician practice” means a physician or a professional association, professional corporation, professional limited liability company, partnership, or other entity formed under the Business Organizations Code or the law of another jurisdiction for the purpose of practicing medicine in this state, including an entity that provides services to patients located in this state by telemedicine.
14. “Private equity group” means a person, including a fund, pool, or syndicate, that primarily engages in the business of acquiring equity or debt interests in companies with capital raised from investors, together with its affiliates and portfolio companies. The term does not include a natural person or a company that is wholly owned by physicians.
15. “Professional fees” means all amounts charged, billed, or collected for medical services rendered by or under the delegation of a physician, from any payor, regardless of who bills or collects them.
16. “Restrictive covenant” means a noncompetition agreement, nonsolicitation agreement, nondisclosure agreement, nondisparagement agreement, or similar provision, however titled, that restricts a physician’s ability to practice medicine, to communicate, or to leave an arrangement, and includes any provision that imposes a financial penalty, repayment

obligation, forfeiture, loss of deferred compensation, liability for tail malpractice coverage, or notice period exceeding 90 days on a physician who leaves or competes, and any provision under which a physician's medical staff membership or privileges terminate or lapse because a contract between a facility and a physician practice ends.

17. "Wholly owned by physicians" means that every equity interest, voting right, option, warrant, profits interest, and right to designate a governing body member is held directly by physicians licensed in this state or in another state, or by an entity that is itself wholly owned by such physicians; that physicians licensed in this state hold a majority of the equity and voting interest; and that no management services organization, private equity group, contract management group, facility, or other person who is not a physician holds any such right or any de facto control.
18. "Adverse action" means terminating, suspending, or declining to renew a physician's employment, contract, or engagement; denying, restricting, suspending, revoking, or declining to renew medical staff membership or clinical privileges; removing a physician from a schedule, call rotation, or service line, or reducing the physician's hours, patients, or compensation; initiating or causing to be initiated a peer review, focused professional practice evaluation, or investigation; making a report to the National Practitioner Data Bank or the board; or threatening any of the foregoing.
19. "Responsible officer" means an individual who serves as chief executive officer, chief operating officer, president, chief medical officer, managing member, general partner, or in any other position that carries authority to adopt, approve, enforce, or rescind a policy of a management services organization, contract management group, private equity group, facility, or nonprofit health organization, or who directs the enforcement of such a policy, regardless of title.

Sec. 166.002. CONSTRUCTION; RELATIONSHIP TO OTHER LAW. (a) This chapter codifies and does not limit the prohibition on the corporate practice of medicine recognized under this subtitle, the Business Organizations Code, and the common law of this state.

b. This chapter does not prohibit a physician practice from obtaining management services, financing, facilities, or equipment from a person who is not a physician on terms that comply with this chapter.
c. This chapter shall be liberally construed to accomplish the purposes stated in Section 2 of the Act enacting this chapter, and a court or the board shall look to the substance of an arrangement rather than its form.
d. This chapter applies to the practice of medicine on a patient located in this state regardless of the law under which the physician practice, or any person providing services to or holding an interest in it, is organized, and regardless of the state of organization of a management

services organization, contract management group, or facility. A choice-of-law, forum-selection, or arbitration provision that purports to avoid this chapter is void.

Sec. 166.003. RULES. The board shall adopt rules necessary to implement this chapter, including rules establishing the form and content of the disclosures required under Subchapter E, not later than March 1, 2028.

SUBCHAPTER B. PROTECTION OF PHYSICIAN PROFESSIONAL JUDGMENT

SUBCHAPTER B. DECISIONS RESERVED TO PHYSICIANS

Sec. 166.051. CLINICAL DECISIONS. A person who is not a physician may not control, direct, intervene in, or condition compensation or continued engagement on a physician's:

1. diagnosis, treatment, correction, change, manipulation, relief, or prevention of disease, deformity, defect, injury, or other physical or mental condition, including the prescription, dosage determination, or administration of a drug, biologic, anesthetic, device, or other therapeutic or diagnostic substance or technique;
2. selection or use of a type or quality of medical supply, device, or pharmaceutical;
3. decision to admit, transfer, discharge, or refer a patient, or the person to whom a referral is made;
4. amount of time spent with a patient, or the number of patients the physician sees in a period;
5. ordering of a diagnostic test, procedure, or consultation, or decision not to order one;
6. diagnostic or procedural coding of an encounter;
7. content of the medical record, including a requirement to document a service, finding, or diagnosis the physician did not render or make;
8. communication with a patient about the patient's condition, treatment options, cost, the physician's employment or contractual status, or the identity of the person that owns or controls the practice; or
9. compliance with a professional standard, clinical protocol, or practice guideline relating to the practice of medicine, other than a requirement to comply with law.

b. This section does not prohibit a clinical protocol, guideline, or quality measure adopted by a committee composed of a majority of physicians who practice in the network, facility, or organization to which it applies, approved by the medical staff where one exists, and applicable to physicians who have agreed in writing to participate. A person may not condition a physician's compensation on adherence to such a protocol except through a quality incentive that the same committee designs, and the physician's judgment in an individual case prevails over the protocol.

Sec. 166.052. PRACTICE GOVERNANCE DECISIONS. A person who is not a physician may not hold final decision-making authority over a physician practice's:

1. hiring, discipline, suspension, or termination of a physician, physician assistant, advanced practice registered nurse, or other person who provides clinical services;
2. terms of employment or engagement of a person described by Subdivision (1), including compensation, productivity targets, and performance metrics;
3. work schedules and clinical staffing levels;
4. clinical policies and standards of care;
5. billing and collection policies, including the decision whether to bill a patient or pursue collection;
6. fees charged to patients, and the negotiation, execution, performance, enforcement, or termination of a contract with a payor;
7. ownership and custody of medical records;
8. marketing or advertising of the practice's services, including under a name other than the practice's own;
9. the sale, transfer, encumbrance, or dissolution of the practice or a majority of its assets; or
10. the declaration or payment of a dividend or distribution from the practice.

Sec. 166.053. PERMITTED ASSISTANCE. Sections 166.051 and 166.052 do not prohibit a person from assisting, advising, or consulting with a physician practice on a decision described by those sections, providing data or recommendations, or performing the administrative work needed to carry out a decision the physician practice has made, if the physician practice retains and exercises final authority over the decision and the person does not exercise de facto control. Assistance does not include ranking, scoring, or comparing physicians on coding level, billing intensity, or revenue per encounter, querying a physician more than once about the documentation or coding of the same encounter, or presenting such information to a physician in connection with compensation, scheduling, or renewal, and such conduct is control for purposes of Section 166.051(6).

Sec. 166.054. DECISIONS REMAIN WITH PHYSICIANS REGARDLESS OF FORM. A provision of an agreement, bylaw, operating agreement, or other instrument that purports to transfer a decision described by Section 166.051 or 166.052 to a person who is not a physician, or that penalizes a physician for making such a decision, is void and unenforceable. A physician who declines to follow a direction prohibited by this subchapter does not breach the agreement under which the direction was given.

Sec. 166.055. PHYSICIAN STAFFING, DELEGATION, AND PATIENT VOLUME. (a) The following are clinical decisions reserved to physicians, and a person who is not a physician may not control, direct, or condition compensation or continued engagement on them:

1. whether a patient is evaluated or treated by a physician or by a nonphysician practitioner acting under physician delegation;
2. the number of nonphysician practitioners a physician supervises, and the scope of acts the physician delegates to each, within the limits of Chapter 157;
3. the number of patients a physician evaluates in a shift or other period, the number of patients assigned to a physician at one time, and the time the physician spends with each; and
4. the number and qualifications of physicians required to safely staff a department, service line, or practice location.

b. A person may not impose on a physician, or on a physician practice, a quota, target, ratio, or productivity requirement that is based on patient volume, relative value units, encounters per hour, billing intensity, or a similar measure, as a condition of compensation, continued engagement, scheduling, or contract renewal, or penalize a physician for failing to meet one. A physician practice wholly owned by physicians may set compensation for its own physicians by any lawful method the physicians choose.

c. A person may not require a physician to supervise or delegate to more nonphysician practitioners than the physician determines can be safely supervised, and may not condition a physician's engagement, scheduling, or compensation on agreeing to supervise a specified number of nonphysician practitioners.

d. A facility, physician practice, management services organization, or contract management group may not reduce or eliminate physician coverage of an emergency department, intensive care unit, anesthesia service, labor and delivery service, or hospitalist service and substitute coverage by nonphysician practitioners unless the substitution is approved in writing by the physicians who provide services in that department or service and, at a hospital, by the medical staff under its bylaws adopted under Section 241.101, Health and Safety Code.

e. A hospital emergency department and a freestanding emergency medical care facility shall have at least one physician physically present and immediately available to patients at all times the department or facility is open. The Health and Human Services Commission by rule may grant a hospital located in a county with a population of 50,000 or less a waiver from this subsection on a finding that no physician is reasonably available, and shall publish each waiver granted.

f. A patient is entitled to be told, before nonemergency treatment begins and on request at any time, whether the person treating the patient is a physician, and a patient who requests evaluation by a physician shall be evaluated by one within a clinically appropriate time. A person who provides clinical services shall comply with Chapter 104 in identifying the person's license to patients.

Sec. 166.056. MEDICAL DIRECTORS. (a) This section applies to a medical director designated by any person, including a facility, a physician practice, a management services organization, or a contract management group.

b. A person may not designate, and a physician may not serve as, a medical director unless the physician:

1. holds a license to practice medicine in this state that is not restricted or on probation;
2. is certified by, or is actively pursuing initial certification with, a specialty board recognized by the board, in the specialty of the physicians the medical director supervises or, for an emergency department, in any specialty;
3. has completed not less than five years of clinical practice after completing residency training in the specialty of the physicians the medical director supervises or, for an emergency department, not less than five years of emergency department practice in any specialty;
4. actively engages in direct patient care at the facility, department, or practice location the physician directs, for not less than 32 hours in each calendar month; and
5. has been nominated or approved by a majority vote of the physicians the medical director will supervise, taken by secret ballot, and has not been removed by a two-thirds vote of those physicians.

c. A medical director:

1. exercises authority over clinical, staffing, scheduling, and quality matters on behalf of, and is accountable to, the physicians the director supervises and, at a hospital, the medical staff;
2. may not be compensated, in whole or in part, by reference to the reduction of physician staffing or hours, the ratio of nonphysician practitioners to physicians, patient volume, billing intensity, cost reduction, or any other financial metric of a facility, management services organization, contract management group, or private equity group;
3. may not direct a physician to take an action prohibited by this chapter and may not be removed, penalized, or denied renewal for refusing to carry out such a direction; and
4. may be removed by a person who is not a physician only for a reason stated in writing that relates to the medical director's own conduct, license status, or clinical competence, and only after notice to the physicians the director supervises.

d. The board by rule may waive the requirement of Subsection (b)(3) for a facility in a county with a population of 50,000 or less on a showing that no physician who meets the requirement is reasonably available, for a period not to exceed two years.

e. This section does not limit the authority of a hospital's medical staff under Section 241.101, Health and Safety Code, or under its bylaws, to impose additional qualifications or a

different selection method for a medical director, if the method gives the physicians of the affected department at least the approval and removal rights provided by Subsection (b)(5).

f. A person who designates a medical director in violation of this section, and a physician who knowingly serves in violation of it, commits a violation of this chapter.

g. This section does not apply to a physician whose duties are limited to system-level administration, quality oversight, or regulatory compliance and who does not supervise, schedule, evaluate, or set compensation for individual physicians at a facility, department, or practice location.

Sec. 166.057. CLINICAL STAFFING AND VOLUME DATA. On request of a physician who provides services at a facility, department, or practice location, the person that schedules the physician shall provide, within 14 days, the physician-to-patient staffing ratios, patient volumes, and nonphysician practitioner coverage for that location for the preceding 12 months. Information provided under this section may be shared with the board, the medical staff, and the physician's attorney and is not subject to a nondisclosure agreement.

Sec. 166.058. EMERGENCY DEPARTMENT STAFFING; NO DISCRIMINATION BY SPECIALTY CERTIFICATION. (a) A physician licensed in this state may provide emergency medical care in a hospital emergency department or a freestanding emergency medical care facility regardless of the specialty in which the physician trained or is certified, subject only to credentialing and privileging by the medical staff on the basis of the physician's individual training, experience, and demonstrated competence.

b. A facility, physician practice, management services organization, contract management group, payor, or other person may not:

1. require certification by the American Board of Emergency Medicine, the American Osteopathic Board of Emergency Medicine, or any other specialty board as a condition of a physician's employment, engagement, scheduling, credentialing, privileging, or participation in a contract to provide emergency physician services, or exclude a physician from emergency department practice because the physician is certified in family medicine, internal medicine, or another specialty, or is not certified in emergency medicine;
2. adopt or apply a policy statement, guideline, accreditation standard, or staffing standard of a professional society, accrediting body, payor, or staffing company that has the effect described by Subdivision (1);
3. compensate a physician at a lower hourly, shift, per-encounter, or productivity-based rate, or with lesser benefits, for emergency department services than it pays another physician for the same services at the same facility, on the basis of the specialty in which the physician is certified or trained; a difference in compensation must rest on individual factors, such as years of emergency department experience, hours scheduled, administrative duties, or documented performance, applied uniformly without regard to specialty certification; a job

title, tier, or shift designation that correlates with specialty certification is evidence of a violation, and the person bears the burden of proving a difference in the services actually performed; or

4. represent to a payor, a patient, or the public that a physician described by Subsection (a) is unqualified to provide emergency care because of the physician's specialty.

c. This section does not:

1. limit the authority of a hospital's medical staff under Section 241.101, Health and Safety Code, to credential and privilege individual physicians on the basis of individual training, experience, and competence, provided that the criteria do not exclude a physician on the basis of specialty certification;
2. require a facility to grant privileges to a physician who does not meet criteria applied under Subdivision (1); or
3. affect a physician qualification requirement in a rule of the executive commissioner of the Health and Human Services Commission for a facility designated under Chapter 773, Health and Safety Code, except that a rule may not exclude a physician from emergency department practice on the basis of specialty certification alone where the physician meets the rule's individual training and experience requirements.

d. A physician harmed by a violation of this section may bring an action under Section 166.253, and for a violation of Subsection (b)(3) is entitled to recover the difference between the compensation paid and the compensation paid to the highest-paid physician performing the same services at the same facility, for the period of the violation.

Sec. 166.059. PHYSICIAN'S RIGHT TO DECLINE; ADVERSE ACTION BY FACILITY OR ADMINISTRATOR. (a) In this section, "adverse action" means terminating, suspending, or declining to renew a physician's employment, contract, or engagement; denying, restricting, suspending, revoking, or declining to renew medical staff membership or clinical privileges; removing a physician from a schedule, call rotation, or service line, or reducing the physician's hours, patients, or compensation; initiating or causing to be initiated a peer review, focused professional practice evaluation, or investigation; making a report to the National Practitioner Data Bank or the board; or threatening any of the foregoing.

b. A physician may decline to perform, order, continue, or supervise a surgery, procedure, treatment, admission, discharge, transfer, prescription, or delegation that the physician determines, in the physician's professional judgment, is not medically indicated, is unsafe for the patient, cannot be performed safely with the staffing, equipment, or facilities available, or is outside the physician's training or competence. A decision under this subsection is a clinical decision reserved to the physician under Section 166.051.

c. A facility, responsible officer, administrator, physician practice, management services organization, or contract management group may not take or cause an adverse action against a physician because the physician:

1. declined as described by Subsection (b);
2. exercised any other decision reserved by this subchapter, refused a direction prohibited by this chapter, or insisted on a staffing level, equipment, or consultation the physician judged necessary for patient safety;
3. advocated for a patient, including by seeking transfer, a second opinion, or a higher level of care;
4. made a report or communication protected by Section 166.152 or 166.356(e); or
5. declined to meet a target or condition described by Section 166.055(b) or 166.356(c).

d. An adverse action taken within one year after conduct described by Subsection (c) is presumed to be retaliatory. The person who took the action may rebut the presumption only by proving by clear and convincing evidence that the action was taken for a bona fide reason relating to the physician's clinical competence or conduct, that the reason was documented before the protected conduct or arose independently of it, and that the action was recommended by a committee of the medical staff composed of physicians in the same or a similar specialty after a hearing conducted under the medical staff bylaws at which the physician was represented by counsel.

e. A peer review action, focused professional practice evaluation, investigation, or report that is retaliatory under this section is not a medical peer review action for purposes of Chapter 160 of this code or Section 161.032, Health and Safety Code, and is not entitled to the privileges, confidentiality, or immunities that state law confers on medical peer review. In an action under this section, a person who claims immunity under the Health Care Quality Improvement Act of 1986 (42 U.S.C. Section 11111) bears the burden of proving that the action met each standard of 42 U.S.C. Section 11112(a), and a finding that the action was retaliatory under Subsection (d) is evidence that the action was not taken in the reasonable belief that it furthered quality health care. A person who participates knowingly in a retaliatory action is individually liable under Section 166.253.

f. The governing body of a hospital may not take an adverse action relating to medical staff membership or clinical privileges except on the recommendation of the medical staff made under its bylaws or for a reason relating to the physician's license status, exclusion from a federal health care program, or indictment or conviction. This subsection does not limit the governing body's authority under Section 241.101, Health and Safety Code, to approve or deny a medical staff recommendation.

g. A facility may not condition medical staff membership or clinical privileges on a physician's employment by or contract with the facility or a person it designates, on the physician's

referral patterns or admissions volume, on the physician's financial performance, or on the physician's agreement to a target described by Section 166.055(b). A facility shall continue a physician's medical staff membership and clinical privileges for not less than 180 days after a physician services contract under which the physician provided services ends, may not condition continuation on the physician joining a successor contractor, and may not treat the end of the contract as a ground for adverse action.

h. A physician subjected to an adverse action in violation of this section may bring an action under Section 166.253 and is entitled to reinstatement of employment, contract, schedule, membership, and privileges; back pay and lost income; compensatory damages, including damage to reputation; exemplary damages under Section 166.253(b); and attorney's fees. On a showing of a prima facie violation, a court shall grant a temporary restraining order and temporary injunction restoring the physician's privileges and schedule pending trial, and bond may not exceed $1,000. A report to the National Practitioner Data Bank or the board that arose from a retaliatory action shall be voided or corrected by the reporting entity on order of the court or the board.

i. A responsible officer who knowingly takes or directs an adverse action in violation of this section, or who directs that a surgery, procedure, or treatment a physician has declined under Subsection (b) be performed by another person, is subject to Section 166.257(b-1).

SUBCHAPTER C. MANAGEMENT SERVICES ORGANIZATIONS

SUBCHAPTER C. MANAGEMENT SERVICES ORGANIZATIONS

Sec. 166.101. AGREEMENTS AUTHORIZED. A physician practice may enter into a written management services agreement with a management services organization for management services that comply with this chapter.

Sec. 166.102. PERMITTED SERVICES. Under a management services agreement, a management services organization may provide to a physician practice:

1. facilities, and repair, maintenance, renovation, or replacement of facilities;
2. medical supplies and equipment, instruments, and business, office, and other nonmedical equipment, other than prescription drugs and other than a device the physician practice is required by law to own or control;
3. accounting, payroll, bookkeeping, budgeting, tax compliance, and similar financial services;
4. information systems and services, provided that patient records in those systems are owned by and freely accessible to the physician practice at all times, including after termination of the agreement;
5. billing and collection of the physician practice's fees in accordance with policies set by the physician practice, and the purchase of the practice's accounts receivable at fair market

value;

6. advertising, marketing, and public relations services in compliance with board rules;
7. assistance with payor contract negotiation and drafting, including analysis and recommended criteria for reimbursement rates;
8. receptionist, scheduling, messaging, and similar coordination services;
9. assistance in obtaining licenses, permits, and registrations;
10. recruiting, continuing education, training, legal assistance, and logistical support for peer review;
11. insurance, purchasing, and claims services;
12. consulting, business, and financial planning services;
13. collection, analysis, and submission of quality and patient satisfaction information;
14. employment of persons who perform management, administrative, clerical, billing, and other nonclinical functions, and of physicians who perform only administrative duties, provided that a physician employed by the organization may not provide clinical services to patients of a physician practice the organization manages, and administrative compensation paid to a physician who holds an interest in such a practice is subject to Section 166.103(15); and
15. employment of clinical support personnel, provided that a physician of the physician practice present at the practice location controls the clinical duties and performance of those personnel and may suspend or remove them from clinical duties for clinical reasons.

Sec. 166.103. PROHIBITED ACTS. A management services organization or MSO agent may not:

1. engage in an act prohibited by Section 166.051, 166.052, or 166.055, or exercise de facto control over a physician practice;
2. employ or engage a physician, by employment agreement or independent contractor agreement, to practice medicine;
3. own, directly or indirectly, any equity interest in a physician practice to which it provides management services, or hold an option, warrant, proxy, voting trust, or other right to acquire or vote such an interest;
4. enter into or enforce an agreement that controls or restricts the sale, transfer, or encumbrance of the equity or assets of a physician practice, except as permitted by Section 166.105;
5. cause a physician practice to issue, redeem, or transfer equity;
6. serve, or cause an MSO agent to serve, contemporaneously as an owner, director, manager, officer, or employee of both the management services organization and a physician practice it manages;
7. control the declaration or payment of a dividend or distribution by a physician practice, or require a physician practice to distribute to the organization an amount determined by

reference to the practice's net income other than through a fee that complies with Section 166.104;

8. acquire, or finance the acquisition of, a majority of the equity of a physician practice;
9. own the medical records of a physician practice's patients, or deny the practice access to them;
10. own or control prescription drugs or controlled substances for use in patient treatment, except as authorized by state or federal law;
11. require a physician to make a referral to the organization, an affiliate, or any other person;
12. retaliate against, penalize, or terminate a physician or physician practice for exercising a decision reserved by Subchapter B, for reporting a suspected violation of law, or for communicating with the board, a patient, or a public official;
13. structure an arrangement, directly or through affiliates, nominees, or a series of transactions, to accomplish an act prohibited by this section;
14. hold a security interest in the professional fees, accounts receivable, or medical records of a physician practice, or hold a right to accelerate, call, or declare a default under a loan to a physician practice on the basis of any decision reserved to physicians by Subchapter B, the practice's clinical volume, the physicians' compensation, or the loss or renegotiation of a payor or facility contract;
15. pay, directly or through an affiliate, compensation of any kind to a physician who holds an ownership interest in a physician practice the organization manages, other than fair-market-value compensation for administrative services that is disclosed to the board under Section 166.201, does not exceed 25 percent of the physician's total compensation from all sources, and is not contingent on the practice's revenue, volume, or the renewal of the management services agreement; or
16. be owned or controlled by, or affiliated with, a health benefit plan issuer, health maintenance organization, or pharmacy benefit manager, or manage a physician practice that participates in the network of an affiliated issuer or health maintenance organization.

Sec. 166.104. FEES. (a) A management services organization may charge a physician practice only a fee that is set in advance in the management services agreement, is consistent with fair market value for the services actually provided, and is not determined by or does not vary with the volume or value of patient referrals, the number of patients seen, or the revenue or net income of the physician practice, except that a fee stated as a fixed percentage of collections for billing and collection services is permitted if the percentage is consistent with fair market value for those services.

b. A fee that results in the management services organization receiving, in a calendar year, more than the physician practice's net income after physician compensation at fair market value is presumed not to comply with this section.

c. The aggregate of all payments by a physician practice to a management services organization and its affiliates in a calendar year, for any purpose, including fees, rent, equipment leases, purchases, interest, and reimbursements, that exceeds 40 percent of the practice's net collections for that year is presumed not to be fair market value. The organization bears the burden of rebutting the presumption with an independent valuation filed with the board under Section 166.201.

Sec. 166.105. PERMITTED TRANSFER RESTRICTIONS. A management services agreement or related agreement may require a physician owner of a physician practice to transfer the physician's interest to another physician, and may restrict transfer to a person who is not a physician, only on:

1. suspension, revocation, or surrender of the physician's license;
2. exclusion, debarment, or suspension of the physician from a federal or state health care program;
3. indictment of the physician for a felony or a crime involving fraud or moral turpitude;
4. the physician's death, disability, or permanent incapacity; or
5. a material, uncured breach of the management services agreement by the physician practice, as determined by a court or arbitrator and not by the management services organization.

Sec. 166.106. PHYSICIAN-OWNED ORGANIZATIONS. Sections 166.103(3), (5), (6), (7), and (8) do not apply to a management services organization that is wholly owned by physicians as defined by Section 166.001(17), in which physicians licensed in this state hold a majority of the equity and voting interest, and in which no private equity group, facility, or other person who is not a physician holds any interest.

Sec. 166.107. PROFESSIONAL FEES BELONG TO PHYSICIANS. (a) Professional fees are the property of the physician or physician practice under whose license the services were rendered, from the moment they are earned, regardless of who bills or collects them and regardless of any assignment, lockbox, sweep, or security arrangement.

b. A person who does not hold a license to practice medicine in this state and does not bear professional liability for the services rendered may not receive, retain, or be paid from professional fees any amount other than:

1. a fee for management services that complies with Section 166.104;
2. fair market rent or purchase price for facilities, equipment, or supplies actually provided, in an arm's-length transaction; or
3. repayment of a loan at a commercially reasonable rate of interest, where the loan is not secured by the equity, professional fees, accounts receivable, or medical records of the physician practice and repayment is not measured by the practice's income, and where a

loan from a person other than a financial institution described by Section 166.001(3) is unsecured and does not exceed the practice's net income for the preceding 12 months.

c. After payment of the amounts permitted by Subsection (b) and the practice's ordinary operating expenses, the remaining professional fees shall be retained by the physician practice and distributed only to its physician owners or paid as compensation to the physicians and personnel who rendered or supported the services.

d. An arrangement under which a person described by Subsection (b) receives, directly or through affiliates, a share of professional fees that increases with the volume of services, the number of patients, or the net income of the practice, other than a billing fee permitted by Section 166.104(a), is fee splitting, is void, and is a violation of this chapter by every party to it other than a physician who reports it to the board under Section 166.254(b).

e. A facility that bills a facility fee for services rendered by a physician does not violate this section with respect to that facility fee. A facility that employs physicians as authorized by Section 162.001 or Subchapter E, Chapter 311, Health and Safety Code, does not violate this section with respect to professional fees it retains under that authority if it complies with Subchapters B and D.

f. A physician may bring an action under Section 166.253 to recover professional fees diverted in violation of this section, and the person who diverted them is liable for the amount diverted plus interest at the judgment rate from the date of diversion.

SUBCHAPTER D. RESTRICTIVE COVENANTS, GAG CLAUSES, AND RETALIATION

SUBCHAPTER D. RESTRICTIVE COVENANTS AND RETALIATION

Sec. 166.151. COVENANTS NOT TO COMPETE PROHIBITED. (a) Notwithstanding Section 15.50, Business and Commerce Code, or any other law, a covenant not to compete, nonsolicitation provision, or other provision that restricts a physician's right to practice medicine in any location, for any period, after the termination of the physician's employment, contract, or engagement is void and unenforceable, regardless of the consideration given for it, and a person may not require a physician to enter into one as a condition of employment, engagement, privileges, scheduling, or a contract with a facility. A provision described by Section 166.001(16), including a repayment obligation, forfeiture, tail-coverage liability, or notice period exceeding 90 days, is void to the same extent as a covenant not to compete, except that a physician may be required to repay the unamortized portion of a documented signing bonus or relocation payment, amortized over not more than two years, if the physician resigns without good cause within that period.

b. A person who requires, enters into, or attempts to enforce a provision described by Subsection (a) commits a violation of this chapter, and the physician may recover under

Section 166.253 the physician's damages and attorney's fees, including the cost of defending an action to enforce the provision.

c. Subsection (a) does not apply to a covenant given by a physician in connection with the sale of the physician's ownership interest, exceeding 10 percent, in a physician practice that is wholly owned by physicians to another physician or to a physician practice that is wholly owned by physicians, if the covenant is limited to one year and five miles, does not outlast the sale, and otherwise complies with Section 15.50(b), Business and Commerce Code. A covenant given in connection with a sale to, or at the direction of, a management services organization, private equity group, contract management group, or facility, or in connection with employment or engagement rather than a sale, is not within this exception.

d. A physician whose employment, contract, or engagement ends for any reason is entitled, on request, to a list of the patients the physician treated during the preceding 12 months and to copies of their medical records on the patient's authorization, and may notify those patients of the physician's new practice location. A provision that prohibits or penalizes that notification is void.

e. A facility may not condition a physician's medical staff membership, privileges, or participation in a coverage contract on the physician's agreement not to practice at another facility, and a provision in a contract between a facility and a physician practice that prohibits the facility from granting privileges to, contracting with, or employing a physician of that practice after the contract ends is void.

Sec. 166.152. NONDISCLOSURE AND NONDISPARAGEMENT. A provision of an agreement between a physician and a management services organization, private equity group, or physician practice is void to the extent it prohibits or penalizes the physician for:

1. reporting a violation of law, or a condition that the physician in good faith believes endangers patients, to the board, a law enforcement agency, a public official, or an accrediting body;
2. communicating with a patient about the patient's care or about who owns or controls the practice;
3. disclosing the terms of the agreement to the board, the attorney general, a court, or the physician's attorney; or
4. speaking truthfully about working conditions or patient safety.

Sec. 166.153. RETALIATION PROHIBITED. (a) A person may not suspend, terminate, reduce the compensation of, or otherwise discriminate or retaliate against a physician because the physician exercised a decision reserved by Subchapter B, refused to follow a direction prohibited by this chapter, or made a report or communication protected by Section 166.152.

b. A physician who is retaliated against in violation of this section may bring an action under Section 166.253 and is entitled to reinstatement, back pay, and the other relief provided by that section. The physician may also file a complaint with the board under Section 166.203.

c. In an action under this section, if the adverse action occurred within one year after the physician's protected act, the adverse action is presumed to be retaliatory and the burden shifts to the person to prove by clear and convincing evidence that it would have taken the same action absent the protected act, as provided by Section 166.059(d).

SUBCHAPTER E. TRANSPARENCY, DISCLOSURE, AND BOARD AUTHORITY

SUBCHAPTER E. DISCLOSURE AND BOARD AUTHORITY

Sec. 166.201. REGISTRATION OF MANAGEMENT SERVICES AGREEMENTS. (a) A physician practice that is party to a management services agreement shall file with the board, in the form the board prescribes, not later than the 30th day after the agreement is executed, amended, or renewed:

1. the name, address, and ownership of the management services organization, including each person that holds 10 percent or more of the organization and each private equity group that holds any interest;
2. the name of each physician owner of the physician practice and the percentage held;
3. a statement of the fee structure; and
4. a copy of the management services agreement and every stock transfer restriction, continuity, succession, option, or financing agreement between the parties or their affiliates.

b. The board shall publish on its Internet website the information described by Subsections (a)(1) and (2). The documents described by Subsection (a)(4) are confidential, are not subject to disclosure under Chapter 552, Government Code, and may be used by the board and the attorney general only for enforcement of this chapter.

c. The board by rule shall set a filing fee in an amount sufficient to cover the cost of administering this chapter, not to exceed $500 for a physician practice with annual net collections of $10 million or less and not to exceed $5,000 for any other filer. Fees collected under this section and civil penalties recovered under Section 166.252 shall be deposited to a dedicated account in the general revenue fund and may be appropriated only to the board and the attorney general for the administration and enforcement of this chapter.

Sec. 166.202. PATIENT NOTICE. A physician practice that is party to a management services agreement, or in which a private equity group holds any interest, shall post at each practice location and on its Internet website, and include in its new-patient materials, a notice in plain

language stating the name of the management services organization or private equity group and the names of the physician owners of the practice. The board by rule shall prescribe the form of the notice, which shall be limited to factual statements of ownership and management.

Sec. 166.203. COMPLAINTS AND INVESTIGATION. (a) Any person, including a physician, patient, employee, or payor, may file a complaint with the board alleging a violation of this chapter.

b. The board may investigate a management services organization, private equity group, or other person that is not a licensee to the extent necessary to determine whether a violation of this chapter has occurred, and for that purpose may issue a subpoena under Section 153.007 to any person.

c. The board shall refer to the attorney general a violation of this chapter by a person who is not a licensee.

Sec. 166.204. ANNUAL REPORT. Not later than December 1 of each year, the board shall report to the legislature the number of management services agreements registered under Section 166.201, the number and disposition of complaints under this chapter, and the identity of each private equity group holding interests in physician practices in this state.

SUBCHAPTER F. ENFORCEMENT

SUBCHAPTER F. ENFORCEMENT

Sec. 166.251. VOID AGREEMENTS. A management services agreement, stock transfer restriction agreement, continuity or succession agreement, restrictive covenant, or other agreement, or a provision of one, that violates this chapter is void and unenforceable as against public policy. A court may sever a void provision and enforce the remainder only if doing so does not leave a person who is not a physician with de facto control of a physician practice.

Sec. 166.252. ATTORNEY GENERAL. (a) The attorney general may bring an action in the name of the state to enjoin a violation of this chapter, to obtain a civil penalty, and to obtain restitution or disgorgement of amounts received in violation of this chapter.

b. A person who violates this chapter is liable for a civil penalty of not more than $10,000 for each violation. Each day of a continuing violation, and each physician practice affected, is a separate violation.

c. A violation of this chapter by a management services organization or private equity group is a false, misleading, or deceptive act or practice under Section 17.46(b), Business and Commerce Code, and the attorney general may pursue the remedies available under Subchapter E, Chapter 17, Business and Commerce Code.

d. The attorney general may recover reasonable attorney's fees and investigative costs in an action under this section.

e. A person who voluntarily provides to the attorney general original information of a violation of this chapter that leads to the recovery of a civil penalty, restitution, or disgorgement under this section is entitled to an award of not less than 15 percent and not more than 30 percent of the amount recovered, determined by the court with reference to the factors in Section 36.110, Human Resources Code. A person is not eligible for an award for information the person was required by law to report, or if the person planned or initiated the violation.

f. A person with original information of a violation of this chapter may bring a civil action in the name of the state under this section. The action shall be filed under seal and served on the attorney general, who may intervene and take over the action not later than the 60th day after service. If the attorney general declines or does not act within that period, the person may proceed with the action and, on recovery, is entitled to not less than 25 percent and not more than 30 percent of the amount recovered, plus reasonable attorney's fees and costs. The procedures of Subchapter C, Chapter 36, Human Resources Code, govern the action to the extent they do not conflict with this section.

g. A person who brings or participates in an action under Subsection (f), or who provides information under Subsection (e), is protected from retaliation as provided by Sections 166.059 and 166.153.

Sec. 166.253. PRIVATE RIGHT OF ACTION. (a) A physician, physician practice, or patient who is harmed by a violation of this chapter may bring an action against the management services organization, MSO agent, private equity group, or other person who committed the violation for:

1. actual damages, or statutory damages of $25,000 for each violation, whichever is greater;
2. injunctive and declaratory relief, including an order unwinding an arrangement that violates this chapter;
3. for a violation of Section 166.153 or 166.059, reinstatement, back pay, and compensatory damages; and
4. reasonable attorney's fees and costs.

b. If the trier of fact finds that the violation was committed knowingly, the court may award exemplary damages not to exceed three times actual damages.

c. A provision requiring arbitration of a claim under this section is unenforceable unless the physician or patient agrees to arbitrate after the claim arises.

d. An action under this section must be brought not later than four years after the date the cause of action accrues, and a cause of action for a continuing arrangement accrues anew each day the arrangement continues.

e. A claim under this chapter is not a health care liability claim under Chapter 74, Civil Practice and Remedies Code, and that chapter, including its expert report, notice, and damages provisions, does not apply to it.

f. The medical staff of a facility, acting through its medical executive committee, and a nonprofit association of physicians organized under the law of this state, may bring an action under this section for injunctive and declaratory relief, and for recovery of amounts under Section 166.356(d)(5), without a showing of individual harm.

g. On a prima facie showing of a violation of Section 166.107, the court shall order the defendant to deposit professional fees collected after the date of suit, less amounts permitted by Section 166.107(b), into the registry of the court or a segregated account pending judgment.

Sec. 166.254. BOARD DISCIPLINE. (a) A physician who knowingly participates in an arrangement that violates this chapter, including by serving as the nominal owner of a physician practice while a person who is not a physician exercises de facto control, is subject to disciplinary action under Subchapter A, Chapter 164.

b. In determining a sanction under Subsection (a), the board shall consider whether the physician was the architect of the arrangement or was subject to economic duress, and shall treat a physician who reports the arrangement to the board before an investigation is opened as a mitigating factor warranting the lowest available sanction.

c. A physician who performs administrative services for a management services organization and who directs or participates in an act prohibited by Section 166.103 is subject to disciplinary action regardless of whether the physician holds an ownership interest in the organization.

Sec. 166.255. NO WAIVER. A waiver of a right or remedy under this chapter is void.

Sec. 166.256. CUMULATIVE REMEDIES. The remedies in this subchapter are cumulative of each other and of any other remedy provided by law.

Sec. 166.257. CRIMINAL OFFENSE: PRACTICE OF MEDICINE BY CORPORATE OFFICER THROUGH POLICY. (a) In this section, “responsible officer” means an individual who serves as chief executive officer, chief operating officer, president, chief medical officer, managing member, general partner, or in any other position that carries authority to adopt, approve, enforce, or rescind a policy of a management services organization, contract management group, private equity group, or facility, or who directs the enforcement of such a policy, regardless of title.

b. A responsible officer who knowingly adopts, approves, enforces, or causes to be enforced, directly or through a contract, a contractor, a subsidy or contract-renewal condition, a management services organization, a contract management group, or any other intermediary, a policy, directive, quota, staffing standard, protocol, compensation formula, target, or

contract term that controls, directs, or conditions a decision reserved to physicians by Section 166.051, 166.052, or 166.055 is practicing medicine in violation of this subtitle for purposes of Section 165.152, whether or not the officer holds a license to practice medicine in another jurisdiction, and commits an offense. Except as provided by Subsection (c), an offense under this subsection is a felony of the third degree.

(b-1) A responsible officer also commits an offense under Subsection (b) if the officer knowingly takes or directs an adverse action, as defined by Section 166.059, against a physician in violation of Section 166.059(c), or knowingly directs that a surgery, procedure, or treatment a physician has declined under Section 166.059(b) be performed by another person. If a patient suffers bodily injury, serious mental harm, or death as a proximate result of the procedure being performed at the officer's direction, of the absence of the physician removed, or of the substitution of a less qualified person, the offense is graded under Subsection (c).

c. An offense under Subsection (b) is:

1. a felony of the second degree if the policy, directive, quota, staffing standard, protocol, compensation formula, or contract term is a proximate cause of bodily injury or serious mental harm to a patient; and
2. a felony of the first degree if it is a proximate cause of the death of a patient.

(c-1) In this section, "bodily injury" and "serious bodily injury" have the meanings assigned by Section 1.07, Penal Code, and "serious mental harm" means a mental or emotional condition that requires inpatient psychiatric treatment or that is diagnosed by a physician as a mental disorder. The state must prove that the responsible officer knew that the policy, directive, quota, staffing standard, protocol, compensation formula, target, or contract term affected a decision described by Section 166.051, 166.052, or 166.055; the state is not required to prove that the officer knew the conduct was unlawful.

d. Knowledge for purposes of Subsection (b) may be inferred from evidence that the policy was adopted in writing or presented to the governing body, or that the responsible officer received written notice from a physician, a medical director, or a medical staff that the policy controlled a decision reserved to physicians and the policy was not rescinded within 30 days after the notice.

e. It is not a defense to prosecution under this section that:

1. a physician could have refused to follow the policy, or did follow it;
2. the policy was described as administrative, financial, operational, or a matter of productivity or efficiency;
3. the responsible officer relied on the advice of counsel or on the practice of other organizations;

4. the organization is organized under the law of another state or provides services through a physician practice it manages; or
5. the harm to the patient was also caused by the act or omission of a physician or other person.

f. It is an affirmative defense to prosecution under Subsection (c) that the responsible officer rescinded the policy and gave written notice of the rescission to the physicians affected before the injury or death occurred.

g. Each patient injured or killed is a separate offense under Subsection (c), and each day a policy described by Subsection (b) remains in effect is a separate offense under Subsection (b).

h. A management services organization, contract management group, private equity group, or facility whose responsible officer commits an offense under this section is criminally responsible under Chapter 7, Penal Code, and is subject to the fines provided by Section 12.51, Penal Code. On conviction, the organization is ineligible for 10 years to provide management services to a physician practice in this state or to contract with a facility in this state, and the attorney general may bring an action under Chapter 11, Business Organizations Code, to terminate the organization's existence or revoke its registration to transact business in this state.

i. An organization may not indemnify, insure, or reimburse a responsible officer for a fine imposed under this section, and a provision of a contract, bylaw, or insurance policy purporting to do so is void.

j. An offense under this section may be prosecuted by the district attorney or county attorney of any county in which the patient was treated, in which the organization maintains an office or does business, or in which a facility affected by the policy is located. The board shall refer evidence of an offense under this section to those prosecutors. The attorney general may assist in the prosecution and, with the consent of the prosecutor, which may not be unreasonably withheld, may conduct it. If no prosecutor has acted on a referral within 180 days, the board shall publish the referral and the prosecutors' responses on its Internet website.

k. A final conviction under this section is conclusive evidence of a violation of this chapter in an action under Section 166.253 brought by the patient, the patient's estate, or a physician, and the responsible officer is personally liable in that action jointly and severally with the organization.

l. This section does not limit prosecution under Section 165.152 or 165.153, or under any other law, for the same conduct.

SUBCHAPTER G AND SECTIONS 4–8. EXEMPTIONS, CONFORMING AMENDMENTS, TRANSITION, EFFECTIVE DATE

SUBCHAPTER G. EXEMPTIONS

Sec. 166.301. EXEMPTIONS. (a) Subchapters C and E do not apply to:

1. a facility, or a nonprofit health organization certified under Chapter 162 of this code or Chapter 844, Insurance Code, with respect to the employment relationship between it and a physician it is authorized by law to employ, except that Subchapters B, D, and H and Sections 166.107, 166.302, and 166.356 apply to every facility and nonprofit health organization and to every physician it employs or contracts with;
2. a federally qualified health center, a rural health clinic, or a program of all-inclusive care for the elderly, except that Subchapters B and D apply to the physicians they employ;
3. a governmental entity, including a medical school, with respect to its governmental immunity only, except that Subchapters B, D, and H and Sections 166.302 and 166.356 apply to a hospital district and to a hospital owned or operated by a governmental entity, and sovereign and governmental immunity are waived to the extent of injunctive and declaratory relief, reinstatement, and back pay under Section 166.253; and
4. a physician practice that is wholly owned by physicians and that itself provides management services to another physician practice.

b. An exemption under this section does not authorize a person to control a decision reserved to physicians by Subchapter B, to designate a medical director in violation of Section 166.056, or to divert professional fees in violation of Section 166.107.

Sec. 166.302. NONPROFIT HEALTH ORGANIZATIONS; ANTI-EVASION. (a) An exemption under Section 166.301 extends only to the exempt entity itself and only to the relationship described in that section. It does not extend to a management services organization, contract management group, private equity group, or other person that provides services to, manages, finances, or holds any interest in or control over the exempt entity, and every agreement between a nonprofit health organization and such a person is subject to Subchapter C as if the nonprofit health organization were a physician practice.

b. A nonprofit health organization certified under Section 162.001(b) that employs physicians who provide services at a facility, or that is affiliated with, funded by, or managed by a facility or a person other than its physician employees, must, in addition to the requirements of Chapter 162:

1. have a board of directors composed solely of physicians licensed in this state, a majority of whom are elected by secret ballot of the physicians the organization employs and are removable only by those physicians;

2. hold and control the professional fees generated by its physicians in its own accounts, and distribute or expend them only as provided by Section 166.107;
3. adopt its physician compensation plan, and any productivity or scheduling standard, only by vote of the physicians it employs;
4. make every management, funding, support, or affiliation agreement with a facility or other person available to its physician employees on request and file it with the board under Section 166.201; and
5. submit its own executive incentive compensation plan, if any, to ratification by its physician employees as provided by Section 166.356(d).

c. A nonprofit health organization, a facility, or any other person may not use a nonprofit health organization, a tax-exempt entity, a physician-owned entity, a professional association, or any other form of organization as a conduit, nominee, or intermediary to accomplish an act that this chapter prohibits a person from accomplishing directly. In determining whether a person has de facto control of a nonprofit health organization, the board and a court shall apply Section 166.001(4) to the organization as if it were a physician practice, and the certification of the organization under Chapter 162 is not evidence that its physicians control it.

d. On a finding that a nonprofit health organization has been used in violation of Subsection (c), or does not meet Subsection (b), the board shall suspend or revoke the organization's certification under Section 162.001, and the organization's employment of physicians is thereafter unlawful until certification is restored. A facility that obtains physician services through an organization whose certification is suspended or revoked violates Section 166.351.

e. The exemption of a facility or nonprofit health organization under Section 166.301 does not apply to any arrangement, policy, or practice that would violate Subchapter B, Subchapter D, Section 166.107, Section 166.356, or this section if undertaken by a management services organization, and a responsible officer of a facility or nonprofit health organization is subject to Section 166.257 to the same extent as a responsible officer of a management services organization.

SUBCHAPTER H. CONTRACTS FOR PHYSICIAN SERVICES AT FACILITIES

Sec. 166.351. DIRECT CONTRACTING REQUIRED. (a) A facility may obtain physician services for its emergency department, anesthesia, hospitalist, intensive care, radiology, pathology, obstetrics, or any other department or service only by:

1. contracting directly with a physician;
2. contracting with a physician practice that is wholly owned by physicians;

3. employing a physician as expressly authorized by Section 162.001 of this code or Subchapter E, Chapter 311, Health and Safety Code;
4. contracting with a medical school or a governmental entity that employs physicians under other law; or
5. engaging an individual physician located through a placement agency described by Section 166.001(2), for not more than 180 days in any 12-month period at one facility, under a contract to which the agency is not a party for the physician's clinical services.

b. A facility may not obtain, and a person may not provide or arrange, physician services at a facility through a contract management group, a staffing company, a management services organization, a private equity group, or any other person that is not described by Subsection (a), whether directly or through a physician practice that such a person owns, manages, finances, or controls.

c. A physician practice described by Subsection (a)(2) may obtain management services from a management services organization that complies with Subchapter C, but the management services organization may not be a party to, guarantor of, assignee of, or beneficiary of the contract with the facility, may not receive the professional fees generated under it except as permitted by Section 166.107, and may not negotiate the contract on the practice's behalf without a physician owner of the practice present and holding final authority.

Sec. 166.352. REQUIRED AND PROHIBITED CONTRACT TERMS. (a) A contract for physician services between a facility and a physician or physician practice must provide that:

1. all clinical, staffing, scheduling, and delegation decisions described by Subchapter B are made by the physicians providing the services;
2. the medical director for the department or service is selected and removable as provided by Section 166.056;
3. the contract may not be assigned, in whole or in part, to a person not described by Section 166.351(a) without the written consent of the facility's medical staff and of a majority of the physicians providing services under it; and
4. the physicians providing services under the contract are entitled to notice of, and to submit a proposal in response to, any solicitation by the facility for a successor contract.

b. A contract for physician services may not:

1. require a physician to enter into a restrictive covenant prohibited by Subchapter D;
2. contain a provision described by Section 166.151(e);
3. permit the facility, or a person other than a physician, to set patient volume, productivity, or staffing targets for physicians in violation of Section 166.055;

4. condition the award or renewal of the contract on the physician practice's agreement to reduce physician coverage or substitute nonphysician practitioners in violation of Section 166.055(d); or
5. be held by a physician practice in which an owner is employed by, or holds an officer or director position with, the facility or an affiliate of the facility, other than membership on the medical staff or service as an elected medical staff officer.

c. Before terminating without cause or declining to renew a contract for physician services for a department or service, a hospital shall give written notice to the physicians providing services under the contract and to the medical executive committee not later than the 90th day before the termination or expiration, and the medical executive committee may submit written comment, which the governing body shall consider and respond to in writing before the termination takes effect.

Sec. 166.353. MEDICAL STAFF SELF-GOVERNANCE. Nothing in this subchapter limits the rights of a hospital's medical staff under Section 241.101, Health and Safety Code. A hospital's governing body may not adopt a bylaw, policy, or contract term that delegates to a person not described by Section 166.351(a) any function of the medical staff relating to clinical quality, peer review, credentialing, or the selection of a medical director.

Sec. 166.354. PATIENT NOTICE AT FACILITIES. A facility shall post in its emergency department and on its Internet website, in the form prescribed by the executive commissioner of the Health and Human Services Commission by rule, the name of each physician practice that provides physician services in the emergency department and each other department or service, and shall update the notice not later than the 30th day after a change.

Sec. 166.355. ENFORCEMENT AGAINST FACILITIES. (a) A violation of this subchapter by a facility is a ground for denial, suspension, or revocation of the facility's license and for an administrative penalty under the chapter of the Health and Safety Code under which the facility is licensed, and the Health and Human Services Commission shall investigate a complaint alleging such a violation.

b. A violation of this subchapter by a contract management group, staffing company, management services organization, or private equity group is a violation of this chapter subject to Subchapter F, and the attorney general may enjoin the performance of a contract entered into in violation of Section 166.351.

c. A contract entered into in violation of Section 166.351 is void as between the facility and the person not described by Section 166.351(a), but the physicians who provided services under it are entitled to the professional fees earned for those services, and the facility shall pay for services actually rendered.

Sec. 166.356. EXECUTIVE INCENTIVE COMPENSATION; INDIRECT CONTROL THROUGH CONTRACTORS. (a) A facility may not pay, promise, or award to a responsible officer, as defined by Section 166.257, or to any administrator, compensation, a bonus, equity, or any other incentive that is determined in whole or in part by reference to:

1. the number of patients seen per physician, per hour, or per shift; relative value units, encounters, or billed charges per physician; or any other measure of physician productivity or throughput;
2. the reduction of physician hours, physician staffing, or physician compensation cost, or the ratio of nonphysician practitioners to physicians;
3. the amount, or the reduction, of a subsidy or support payment to a physician practice under a physician services contract; or
4. billing intensity, coding levels, or revenue per encounter for physician services.

b. A facility may base executive compensation on patient safety and quality outcomes, mortality, infection rates, readmissions, patient experience, timely access to a physician, the financial performance of the facility as a whole, and similar measures that do not reward the conduct described by Subsection (a).

c. A facility, a responsible officer, or an administrator may not, directly or through a physician services contract, a subsidy or support-payment negotiation, a contract renewal or rebid, a management services organization, a contract management group, or any other intermediary or means, request, require, encourage, reward, or condition a benefit or the continuation of a contract on a physician practice or its physicians meeting a target described by Section 166.055(b), reducing physician coverage, increasing billing intensity, or substituting nonphysician practitioners for physicians. A request, requirement, or condition described by this subsection is an act of control over a decision reserved to physicians for purposes of Sections 166.055 and 166.257, regardless of whether it is reduced to writing.

d. Medical staff ratification. (1) Not later than December 1 of each year, the governing body of a facility shall deliver to the facility’s medical staff, and at a hospital to the medical executive committee, the proposed incentive compensation plan for the following year for its chief executive officer, chief operating officer, chief financial officer, chief nursing officer, and each administrator with authority over a physician services contract, stating every metric, its definition, and its weight.

2. The plan takes effect only if ratified by a majority of the active members of the medical staff voting by secret ballot at a meeting or by electronic ballot conducted by the medical staff under its bylaws, not later than January 31. A plan that is not ratified, or that is amended by the governing body after ratification without a new vote, is void, and no incentive compensation may be paid under it.

3. Not later than March 1 of each year, the facility shall file with the Health and Human Services Commission the plan, the result of the medical staff vote, and the incentive compensation actually paid under the prior year's plan to each person described by Subdivision (1), and the commission shall publish the filing on its Internet website.
4. A facility, governing body member, or administrator may not take or threaten an adverse action, as defined by Section 166.059, against a physician, or withhold, condition, or reduce a subsidy, support payment, contract, or privilege, because of how the physician or the medical staff voted under this subsection, and such an action is subject to Section 166.059.
5. Incentive compensation paid under a plan that was not ratified, or that violates Subsection (a), is recoverable by the attorney general from the recipient under Section 166.252, and the medical staff, acting through its medical executive committee, may bring an action under Section 166.253 to enjoin the payment and recover the amount paid for the benefit of the facility.
6. The legislature finds that the revenue of a facility is generated by services ordered, performed, or supervised by physicians under their licenses, and that the physicians whose licenses generate that revenue are entitled to approve the terms on which it is paid out as incentive compensation to persons who hold no such license.

e. A physician, employee, or contractor who reports a violation of this section to the board, the commission, the attorney general, the medical staff, or a member of the legislature is protected from retaliation as provided by Sections 161.134 and 161.135, Health and Safety Code, and Section 166.153 of this code, and a nondisclosure or confidentiality provision does not apply to such a report.

f. A violation of this section by a facility is subject to Section 166.355. Incentive compensation paid in violation of Subsection (a) is recoverable by the attorney general from the recipient, and the recipient is a responsible officer for purposes of Section 166.257 with respect to any policy, target, or condition adopted while the incentive was in effect.

g. This section does not prohibit a co-management or quality incentive agreement under which a physician practice is compensated for quality, safety, or efficiency outcomes, if the metrics are set by the practice's physicians, no metric rewards reducing physician hours, reducing physician coverage, or substituting nonphysician practitioners for physicians, and the agreement is filed with the board under Section 166.201.

SECTION 4. Section 162.001, Occupations Code, is amended by adding Subsection (e) to read as follows:

e. A health organization certified under this section is subject to Subchapters B, D, and H and Sections 166.107, 166.302, and 166.356, Chapter 166, with respect to each physician it employs or engages and each facility or person with which it contracts.

f. The board shall adopt rules requiring, as a condition of initial and continued certification under Subsection (b), that a health organization comply with Section 166.302(b), and shall suspend or revoke certification as provided by Section 166.302(d). The board shall review each certified organization's compliance not less than once every two years and on complaint.

SECTION 5. Section 164.052(a), Occupations Code, is amended by adding Subdivision (__) to read as follows [Texas Legislative Council assigns the number; the subdivision list currently ends in the low twenties after the 2023 amendments]:

(__) knowingly participates in an arrangement that violates Chapter 166, serves as a medical director in violation of Section 166.056, or enters into or seeks to enforce a covenant prohibited by Section 166.151.

SECTION 6. Section 15.50, Business and Commerce Code, is amended by adding Subsection (d) to read as follows:

d. Notwithstanding Subsection (b), a covenant not to compete relating to the practice of medicine by a physician licensed by the Texas Medical Board that is entered into, renewed, or extended on or after September 1, 2027, is enforceable only to the extent permitted by Section 166.151, Occupations Code. Subsection (b) continues to govern a covenant entered into before that date until the covenant is renewed or extended.

SECTION 6A. Section 241.101, Health and Safety Code, is amended by adding Subsection (h) to read as follows:

h. The governing body of a hospital shall comply with Subchapter H, Chapter 166, Occupations Code, in obtaining physician services, and may not delegate to a person described by Section 166.351(b), Occupations Code, any function of the medical staff.

SECTION 7. TRANSITION. (a) Subchapters B, D, and F, Chapter 166, Occupations Code, as added by this Act, apply to an agreement entered into, amended, renewed, or extended on or after the effective date of this Act, and to a decision made or an act taken on or after that date under any agreement regardless of when the agreement was entered into.

b. Subchapter C, Chapter 166, Occupations Code, as added by this Act, applies to:

1. a management services organization or physician practice formed, acquired, or sold on or after the effective date of this Act, beginning on the effective date of this Act;
2. a management services organization or physician practice in existence on the effective date of this Act, beginning on the earlier of September 1, 2030, or the date of any transaction or series of transactions after the effective date that transfers 10 percent or more of the equity, economic, or profits interest in the organization, the practice, or any parent, or that refinances, amends, restates, extends, or renews a management services agreement, stock

transfer restriction agreement, continuity or succession agreement, or financing agreement between them.

c. The disclosure required by Section 166.201, Occupations Code, as added by this Act, is due for an existing agreement not later than March 1, 2028.

d. An agreement that is lawful on the date it was entered into but that would violate Subchapter C after the date it becomes subject to that subchapter must be amended or terminated before that date. A party to such an agreement may terminate it without penalty on 90 days' notice given before that date, and a termination under this subsection does not breach the agreement or trigger a restrictive covenant.

e. Subchapter H, Chapter 166, Occupations Code, as added by this Act, applies to a contract for physician services at a facility that is entered into, renewed, or extended on or after the effective date of this Act, and beginning September 1, 2029, to every such contract regardless of when it was entered into. A facility or physician practice may terminate a contract that will become unlawful under this subsection without penalty on 180 days' notice.

f. A physician serving as a medical director on the effective date of this Act may continue to serve until September 1, 2028, after which the physician must meet the requirements of Section 166.056, Occupations Code, as added by this Act, including approval by the physicians the medical director supervises.

g. Section 166.055(e), Occupations Code, as added by this Act, applies beginning September 1, 2028, to give facilities time to recruit physicians and to apply for a waiver.

h. Section 166.151, Occupations Code, as added by this Act, applies to a covenant entered into, renewed, or extended on or after the effective date of this Act. A covenant entered into before that date remains governed by Section 15.50(b), Business and Commerce Code, as it existed on the day before the effective date of this Act, but is void if the physician is discharged without good cause as that term is defined by that section.

SECTION 8. SEVERABILITY. If any provision of this Act or its application to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of this Act that can be given effect without the invalid provision or application, and to this end the provisions of this Act are severable.

SECTION 9. EFFECTIVE DATE. This Act takes effect September 1, 2027.

Appendix: sponsor checklist, expected opposition, and sources

The bill's hardest fights are Subchapter H (hospitals lose the staffing-company model) and the flat noncompete ban (it repeals the compromise the Legislature just passed in 2025); its strongest selling point is that it bans nothing a physician-owned practice does today.

Sponsor checklist:

- ☐ Identify a Senate author on Health and Human Services (Kolkhorst chairs; Hancock carried the 2025 ownership-reporting bill, SB 1595, and is a natural ally; Hinojosa carried the 2025 veterinary private-equity bill and may cross over)
- ☐ Find a House companion author (Oliverson carried HB 2982 in 2023 and is a physician)
- ☐ Brief Texas Medical Association, Texas College of Emergency Physicians, Texas Society of Anesthesiologists, and Texas Academy of Family Physicians before filing; TCEP and TSA members are the ones working under contract management groups and are the natural witnesses for Subchapter H
- ☐ Expect Texas Hospital Association opposition to Subchapter H and Sec. 166.055(e); line up rural physicians who can testify that the waiver process works
- ☐ Request a Legislative Budget Board fiscal note that treats the Sec. 166.201 filing fee as covering TMB's cost and the HHSC facility-enforcement cost as absorbed within existing licensing activity
- ☐ Submit to Texas Legislative Council for drafting conformance; TLC must assign the 164.052(a) subdivision number, confirm the Health and Safety Code citations (Chapters 241, 243, 254; Sec. 241.101), and confirm Sec. 301.152 is the right APRN definition
- ☐ Sec. 166.151(c) (sale-of-practice exception): decided, keep
- ☐ Pre-file on or after November 9, 2026

Expected opposition and responses:

Objection	Who raises it	Response built into the draft
Bans MSOs and cuts off capital to practices	PE firms, MSO trade groups, Texas Association of Business	Sec. 166.102 lists 15 categories of permitted services; Sec. 166.101 expressly authorizes MSO agreements; only control, ownership, and profit-stripping are barred
Hospitals cannot staff emergency departments without contract management groups	Texas Hospital Association, TeamHealth, Envision, SCP, USACS	Sec. 166.351(a)(2) lets any physician-owned group hold the contract, including large ones; physician-owned groups already staff most Texas EDs; Sec. 7(e) gives existing contracts until Sept. 1, 2029 and a 180-day penalty-free exit; the physicians already on site get first shot at the successor contract

Objection	Who raises it	Response built into the draft
Criminalizing executives is overreach and void for vagueness	Hospitals, MSOs, THA, defense bar, some legislators	Sec. 166.257 ties to an offense that has existed for a century (Sec. 165.152), requires a knowing act, requires proximate cause for the aggravated grades, and lists the reserved decisions by section number so the conduct is defined. An executive who sets patient-per-hour quotas is doing what the law has always said only a physician may do; the section only names the person who did it
Lets non-EM-boarded physicians staff EDs and bars specialty-based pay differentials	ACEP, TCEP, EM residency programs, contract management groups	Sec. 166.058 leaves medical-staff credentialing on individual training, experience, and competence; it bars only categorical exclusion by specialty and pay differences based on certification rather than individual factors. FM and IM physicians already staff most rural Texas EDs; TAFP, the Texas ACP chapter, and TORCH are natural supporters. Existing trauma-designation rules are untouched. Expect TCEP to split from the bill on this section
Rural hospitals cannot keep a physician in the ED 24/7	THA, rural hospital association, TORCH	Sec. 166.055(e) waiver for counties under 50,000, published so the public can see which EDs run without a physician; delayed to Sept. 1, 2028. Sec. 166.058 widens the pool of physicians who can fill the shift
Medical-director election usurps hospital governance	THA, hospital boards	Sec. 166.056(e) preserves medical staff bylaws and Sec. 241.101; the bill adds a floor (approval and removal by the physicians directed), not a ceiling

Objection	Who raises it	Response built into the draft
Volume-quota ban makes productivity pay impossible	Hospitals, MSOs, some physician groups	Sec. 166.055(b) exempts practices wholly owned by physicians setting pay for their own physicians; the ban runs only against persons who do not hold the license
Noncompete ban repeals a 2025 compromise and invites a contracts-clause suit	Hospitals, TMA (which negotiated SB 1318), employers	Prospective only (Sec. 7(h)); optional sale-of-practice exception in Sec. 166.151(c); the state's police power over the practice of medicine is at its strongest here, and several states already ban physician noncompetes outright
Existing MSO deals become illegal overnight	PE firms, affected physician groups	Sec. 7 gives existing arrangements until Sept. 1, 2030 and a penalty-free exit; only new or sold entities comply at once
Interferes with freedom of contract	Business groups, some Republicans	Texas already limits physician noncompetes in Sec. 15.50(b); CPOM is a century-old Texas rule; the bill restores the doctrine's substance rather than creating a new one
Telemedicine practices will leave Texas	Telehealth companies	The draft deliberately includes telemedicine; Oregon exempted it and that is the hole most likely to be exploited. Sponsor's call
TMB cannot investigate non-licensees	TMB itself	Sec. 166.203(b) grants subpoena authority under Sec. 153.007, which already carries court enforcement through the attorney general; Sec. 166.203(c) routes non-licensee cases to the AG
Fee cap in Sec. 166.104(b) is arbitrary	MSOs	It is a rebuttable presumption, not a cap; the sponsor may strike (b) and rely on fair-market-value alone

Objection	Who raises it	Response built into the draft
Professional-fees rule conflicts with hospital employment and 501(a) corporations	THA, nonprofit health corporations	Sec. 166.107(e) carves out facility fees and fees retained under lawful employment authority, conditioned on honoring Subchapters B and D

Design choices a sponsor may want to revisit:

- Sec. 166.001(3) uses a 10 percent presumption of control, borrowed from securities and HSR practice; Oregon used majority ownership. Ten percent is the stricter, cleaner line.
- Sec. 166.056(b)(3) sets five years of post-residency practice as the medical-director floor and (b)(4) sets 32 clinical hours a month at the site. Both numbers are the author's; a sponsor may prefer three years and 24 hours. The selection and removal rights in (b)(5) are the part that matters. For an ED, five years of ED practice in any specialty qualifies.
- Sec. 166.058 will cost the bill ACEP's and probably TCEP's support and gain TAFP's and the rural hospitals'. Subsection (c)(3) leaves existing trauma-designation staffing rules alone so Level I and II trauma centers are not an argument against it; a sponsor who wants the section to reach those rules can strike (c)(3).
- Sec. 166.257 is the section most likely to be amended in committee. The grades (third, second, first degree) are the author's; the elements (knowing act, listed reserved decision, proximate cause) are what keep it constitutional. If the committee balks at a first-degree felony, dropping (c)(2) to second degree keeps the structure. Do not accept an amendment that adds "with intent to harm"; that would make the section unprovable.
- Sec. 166.055(e) (physician physically present in every ED) is the single provision most likely to be stripped in committee. If it goes, keep (d), which stops a facility from converting an ED to nonphysician coverage without the physicians' consent.
- Sec. 166.151 is a flat ban on employment and engagement noncompetes. Subsection (c) keeps the one exception every noncompete-ban state keeps, a seller's covenant on a physician-to-physician practice sale, limited to one year and five miles and never available to an MSO, investor, staffing company, or facility buyer. The author decided to keep it; it protects physician-to-physician succession and removes the strongest contracts-clause argument against the ban.
- Sec. 166.202 patient notice is the provision most likely to draw "compelled speech" objections; it is modeled on hospital ownership notices and should survive, but it is severable.
- Sec. 166.253(c) bars pre-dispute arbitration; the Federal Arbitration Act may preempt this for interstate MSOs. Keep it for the state-law signal, expect it to be litigated.

- Subchapter H applies to hospitals, FSEDs, and ASCs. It does not reach nursing homes, dialysis, or urgent care; those can be added by expanding the “facility” definition, at the cost of more opponents.

Sources:

- Texas HB 2982, 88R (2023), introduced text
- Davis Wright Tremaine summary of Oregon SB 951 (June 2025)
- Oregon Legislature staff measure summary, SB 951 B
- Oregon HB 3410 staff measure summary (amendments to SB 951)
- Holland & Knight on Texas SB 1318 (2025) physician noncompete limits
- Texas Hospital Association amicus brief on CPOM and 22 TAC 177.17 (2024)
- Senate HSGAC letter to Blackstone/TeamHealth on ED staffing (Apr. 2024)
- Senate HSGAC letter to Apollo/USACS (Apr. 2024)
- Ivy Clinicians, State of the US Emergency Medicine Employer Market (Mar. 2024)
- Texas Medical Board FAQ on the 1:7 delegation ratio, Sec. 157.0512
- SB 315, 85R (2017), TMB subpoena enforcement under Sec. 153.007
- Winston & Strawn, Texas SB 613 (89R) veterinary private equity bill
- Texas SB 1595, 89R (2025), ownership reporting, Hancock
- Private Equity Stakeholder Project, 2025 State Healthcare Policy Review
- Greenberg Traurig, Continued Scrutiny of Private Equity in Texas (May 2026)
- 90th Legislature key dates