Georgia Economic Credentialing: A Necessary Evil Borne of the Certificate of Need Debate

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Hospital competition has become an increasingly apparent evil for many hospitals in today's national health care market. Competition in an industry is usually good for pricing and quality of service, however, these hospitals are facing competition that differs dramatically from competition in other industries. Hospitals face competition from within. The very doctors that hospitals rely on for a majority of their referrals are competing for the most profitable patients. Physician-owned specialty hospitals are skimming off profitable procedures as physician-owners refer the more costly patients to general hospitals.[1] By focusing on patients with less severe cases, having lower shares of Medicaid patients, failing to provide emergency services, and concentrating on certain diagnosis related groups (DRGs), these specialty hospitals are maximizing profit at the expense of general hospitals.[2]

At the same time, Georgia's healthcare industry is readying itself for another legislative battle. After an overwhelming victory in the 2004 general election, Georgia Republicans held a majority for the first time in many years. They did not waste time in enacting their agenda as in the 2005 session of the General Assembly, legislators again argued over whether tort reform was required to slow the increases in healthcare costs claimed to be tied to malpractice suits. The debate was resolved on February 15, 2005, when Senate Bill 3 was signed into law. Now legislators have turned their attention to another portion of Georgia law in an effort to control health care costs: the Certificate of Need (CON) program. However, this battle differs from the last because it matches the same people who so recently fought together to bring about change: physicians and hospitals.

Currently, Georgia does not have the same problems with physician-owned specialty hospitals because Georgia's CON process requires these facilities to obtain state approval prior to their creation. Non-profit hospitals claim eliminating the CON process will enable physician-owned specialty hospitals to enter the market, thus spelling financial disaster for non-profit hospitals and leading to decreased access for Georgians. Therefore, they wish to keep, and even strengthen, the CON process. Physicians believe that allowing Georgia's health care industry to enter into a free-market system, like other industries, will lower health care costs. Therefore, physicians would rather eliminate, or at least amend, the CON process.

Within the CON debate, one issue that has received must attention: whether to allow for the continued CON exemption for physician-owned, single specialty, free-standing ambulatory (outpatient) surgery centers.[3] Because hospitals claim physician-owned facilities, regardless of their structure, skim of profitable procedures from hospitals, hospitals would like to eliminate this exemption and thereby strengthen the

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[1] *Specialty Hospitals; Information on national Market Share, Physician Ownership, and patients Served*, GAO Report, GAO-03-683R (April 2003) (hereinafter GAO Market Share Report)

[2] Medicare Payment Advisory Committee, Report to Congress: Physician-Owned Specialty Hospitals, 28 (March 2005) (available at http://www.medpac.gov/ publications/congressional_reports/Mar05_SpecHospitals.pdf) (hereinafter MedPAC Report)

[3] Ga. Code Ann. § 31-6-47 (2006)

CON process. Doctors would like to keep this exemption, and further, amend the exemption to include general surgery ASCs, an ASC specialty currently not exempted for the CON process.

Some familiar with the situation see amending this exemption as a means to examine the affect on the health care industry of complete elimination of CON.[4] This exemption, as currently drafted, is inconsistent with the rationale behind CON because it requires physicians to *separately* create ambulatory surgical centers (ASCs) for each physician's group instead of allowing physicians to join forces with other groups and across specialties in order to build mutli-service facilities.[5] Amending this exemption to allow multi-group/specialty ASCs and disallow single group ASCs would aggregate resources needed to build these facilities and thereby reduce total overall expenditure. It would also enable the legislature to analyze the affect of physician-owned facilities on Georgia's health care industry. Further, the author believes that, with amendments to the current staffing laws, hospitals could control any unfair competition by utilizing adverse credentialing strategies. However, if physician enter into joint ventures with hospitals to create these new ASCs, this may not be necessary.

If physicians do not enter into joint ventures to include a hospital in a newly developed ASC, hospitals may be forced out of business by the practices of physicians who "cherry-pick" patients for the ASC.[6] Therefore, tax-exempt hospitals may need additional protections to assist in their economic stability. To provide a means of last resort for these hospitals, the General Assembly should amend the Georgia public hospital staffing laws to explicitly allow for hospital boards to utilize economic criteria when making credentialing decisions.

I. Economic Credentialing

This paper will first describe economic credentialing and how it typically is utilized. Next, the paper will discuss how the CON deregulation proposal could be used to provide hospital boards with a means to control unfair practices through economic credentialing. The paper will then explore how courts nationwide have ruled when faced with economic credentialing issues. Then, the paper will examine how Georgia courts have ruled. In addition, the paper will identify and discuss three areas of concern for non-profit tax-exempt hospitals attempting to use economic criteria in the credentialing process: due process, antitrust, and anti-kickback implications. Lastly, the paper will suggest ways to amend the Georgia staffing laws to explicitly allow for the use of economic criteria in credentialing decisions.

a. What is Economic Credentialing?

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[4] *See* Charles A. Dorminy, Georgia's Certificate of Need: The Affect of Physician-Owned Facilities on Georgia's health care Debate, University of Houston LLM Thesis (forthcoming December 2006); Interview with William Richardson, Chairman, Georgia Hospital Association; Chief Executive Officer, Tift Regional Medical Center, Tifton, Georgia

[5] *See* Ga. Code Ann. § 31-6-47

[6] *See* Joseph A. Parker, A Case for Preserving CON, GHA Today, 13 (July/August 2005) (hereinafter Preserving CON); *See also,* 2007 Legislative Priorities, Medical Association of Georgia, 1 (2006) *available at* http://www.mag.org/default.asp?ID=2 (citing the economic downfall of Rapid City Regional because of the entry of a competing provider into the market); *But see* Medicare Payment Advisory Committee, Report to Congress: Physician-Owned Specialty Hospitals, 22-24 (March 2005) (available at http://www.medpac.gov/ publications/congressional_reports/Mar05_SpecHospitals.pdf) (hereinafter MedPAC Report) (concluding that the financial impact of specialty hospitals on competitor hospitals has been limited thus far)

Generally, only those physicians who maintain admitting privileges at a hospital may practice at that hospital.[7] Although the criteria differ from state to state, typically, the criteria are based on training, experience, and clinical competence.[8] This process of review is sometimes referred to as "credentialing."[9] Typically, the duty of credentialing a physician has been the responsibility of the medical staff, subject to approval of the hospital board.[10] Hospitals usually defer to the medical staff's decision even though they have the ultimate decision making authority.[11] However, hospital boards have recently begun taking their own action, using criteria relating to what financial impact the physician's membership will have on the hospital when determining whether to grant or maintain privileges to a physician.[12] While hospitals continue to rely on the medical staff's evaluation of a physician's clinical practice, hospital boards themselves have begun evaluating the financial impacts of granting and extending privileges.[13] Given the sensitive nature of this subject, however, it is unlikely the decision will be explicitly labeled as made solely on financial criteria.[14] The utilization of financial criteria in the credentialing process is generally referred to as "economic credentialing."[15]

The American Medical Association (hereinafter "AMA") defines economic credentialing as the use of economic criteria unrelated to quality of care or professional competence in determining a physician's qualifications for initial or continuing hospital medical staff membership or privileges.[16] This definition expresses the AMA's position that financial considerations are not related to quality of care.[17] However, some believe economic credentialing has a quality assurance aspect.[18] Economic credentialing implies that a hospital will monitor a physician's practice patterns and make a credentialing decision based on whether a physician is depleting limited resources without improving

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[7] Joint Commission On The Accreditation Of Healthcare Organizations, The Accreditation Manual For Hospitals 53 (1993); *See* 42 U.S.C. §§ 1395x(e), 1395bb; Berkeley Rice, *Economic Credentialing: When Hospitals Play Hardball*, Medical Economics (September 2006) (herein after "Rice Credentialing Hardball") *available at* http://www.memag.com/memag/article/articleDetail.jsp?id=370384

[8] Michael A. Kurs *et al*, *Economic Credentialing: Are Hospital Privileges Contingent upon Skills - or Economics?*, 67 Connecticut Medicine 225 (April 2003) (hereinafter "Kurs"); *See, e.g.,* Ga. Code Ann. §31-7-7

[9] John D. Blum, *The Evolution of Physician Credentialing into Managed Care Selective Contracting*, 22 Am. J. L. & Med. 173, 176 (1996) (hereinafter "Blum") *available at* http://web.ebscohost.com/ ehost/pdf?vid=3&hid=13&sid=63bf4e75-8d8d-40ff-885d-f1a00c1856f5%40sessionmgr7; Sometimes "credentialing" refers to the process of review to determine a particular staff physician's competence in performing a specific procedure or rendering certain treatment. In that case, the term "privileging" would more specifically refer to review of a physician for inclusion on the staff. For simplicity, this paper will refer to all physician review as "credentialing".

[10] *See* Rice Credentialing Hardball, *supra*, note ___, at 1

[11] *See* Brad Dallet, *Economic Credentialing, Your Money or Your Life!*, 4 Health Matrix 325, 329 (1994) (hereinafter "Dallet")

[12] *Id.*; Rice Credentialing Hardball, *supra*, note ___, at 1

[13] *See* Blum, *supra*, note ___, at 182

[14] *Id.*

[15] *See* Kurs, *supra*, note ___, at 225

[16] American Medical Association, Policy H-230.975, *available at* http://www.ama-assn.org/apps/pf_new/pf_online

[17] *See id.*

[18] Neil Olderman, *Legal Aspects of Economic Credentialing – Managing Medical Care Costs*, Physician Executive (November/December 1991) *available at* *http://www.findarticles.com/p/articles/mi_m0843/is_n6_v17/ai_11647238*

the quality of care rendered.[19] A less controversial definition of economic credentialing is the evaluation of a medical staff member based on resource utilization.[20] Although the AMA believes economic criteria should not be utilized during the credentialing process, some courts have shown deference to hospital boards, allowing credentialing decisions based, in part, on the financial impact of the decision.[21]

Opponents of economic credentialing argue that hospitals should limit their analysis to competence, training, and quality of care concerns and should not be allowed to take into account economic impact when making these decisions.[22] Opponents claim it is unethical to put hospitals' financial best interests before patient care.[23] Some physicians claim that this practice violates their right to practice medicine and restricts patients' freedom to choose healthcare providers.[24] Opponents also claim that this power would be abused by hospitals.[25]

Proponents claim hospitals use these criteria to maintain the hospital's economic viability.[26] Financial decisions, they claim, effect quality of care by protecting the hospital financially, enabling the hospital to continue to certain services and improve its overall care.[27] Non-profit hospital boards have a fiduciary responsibility to protect and preserve the charitable mission of the institution, therefore, they must act in a fiscally responsible manner.[28] Without these actions, the hospital would be forced out of business, leaving the community with insufficient access to healthcare.[29]

b. How Does Economic Credentialing Work

Traditionally, economic credentialing has appeared as either or a combination of two strategies: closing the staff for a particular specialty or entering into exclusive contracts for that specialty.[30] To close the staff, the hospital passes a resolution precluding any new physicians from applying for privileges in that certain specialty or for a specific procedure.[31] Although it has no effect on the current staff's ability to continue practicing at the hospital, closing the staff restricts the current staff physicians' ability to recruit additional members to their practice.[32] This may significantly impair the physicians' ability to recruit additional doctors for the specialty hospital.[33]

Exclusive contracting involves the hospital entering into an exclusive contract for a particular specialty or service with a single physicians' group who then employs or

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[19] *Id.*
[20] Albert E. Trentalance, *Economic Credentialing is Here to Stay*, Physician Executive (September 1994) *available at* http://www.findarticles.com/p/articles/mi_m0843/is_n9_v20/ai_15863983
[21] *See e.g.,* Mahan v. Avera St. Luke's, 2001 S.D. 9, 621 N.W.2d 150 (2001)
[22] *See*, Beverly Cohen, *An Examination of the Right of Hospitals to Engage in Economic Credentialing*, 77 Temp. L. Rev. 705, 710
[23] Id.
[24] Howard L. Lang, *Economic Credentialing-Why It Must Be Stopped*, 5 Med. Staff Couns. 19, 24 (1991)
[25]
[26] Elizabeth A. Weeks, *The New Economic Credentialing: Protecting Hospitals from Competition by Medical Staff Memebers*, 36 J. Health L. 247 (Spring 2003) (hereinafter "Weeks")
[27] *See* Mark Taylor, *Doc Investors in For-Profit Hospitals Denied Staff Privileges*, 32 Mod. Health. 12
[28] *See id.*
[29] *See id.*
[30] *See* Weeks, *supra*, note ___, at 249-251
[31] *Id.* at 250
[32] *See* Mahan, 621 N.W.2d at 152
[33] *See id.*

contracts with other physicians in that specialty.[34] Hospitals claim exclusive contracting produces more efficient operations within the department, thereby increasing quality of care.[35] Exclusive contracting is generally accomplished by passing a resolution stating that only those physicians who are under contract with the exclusive provider may admit and treat patients in that specialty.[36] The exclusive provider's employment contract also generally includes a non-compete clause restricting the physician from practicing with any other provider at any other facility.[37] Further, the contract may require the physician to surrender his hospital privileges and therefore, maintain admitting privileges solely through the exclusive provider.[38] Therefore, the physician cannot perform procedures at the competing facility without violating his contract with the exclusive provider.[39] Those physicians who do not enter into contracts with the exclusive provider, or who the exclusive provider does not extend the opportunity to enter into an employment contract, will effectively not be able to practice at the hospital.[40]

Without privileges, the physician cannot practice.[41] Accrediting standards require that physicians who practice at a hospital must maintain privileges at that hospital.[42] Hospitals that allow physicians to practice at the hospital without having privileges at the hospital could lose their Medicare and Medicaid provider agreement.[43] Further, managed care providers often require admitting privileges as a prerequisite to becoming a part of their network of physicians.[44] This gives the hospital significant power over the physician. This power could possibly be utilized effectively to limit competition and provide an added incentive for physicians to include a tax-exempt hospital in the corporate form of an ASC.

c. Using Economic Credentialing in ASC CON Deregulation

The proposed deregulation of the CON process in Georgia arguably limits the hospitals' power to combat competition from ASCs. However, given the regulatory requirements placed on ASCs by the Georgia Department of Community Health, the remaining deregulated ASC CON criteria, and the presence of accreditation standards hospitals should be able to take action to limit competition through economic credentialing.

The current Georgia CON review criteria for ASCs include non-need based standards based on quality and access.[45] Also included in the ASC criteria are standards specific to the intricacies of ASC operations, like standards to insure continuity of care.[46]

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[34] *See* Weeks, *supra*, note ___, at 249
[35] *See* Blum, *supra*, note ___, at 181; Mateo-Woodburn v. Fresno Community Hospital, 270 Cal.Rptr. 894, 897-899 (1990)
[36] *See* Weeks, *supra*, note ___, at 249; Mateo-Woodburn, 270 Cal.Rptr. at 897
[37] Mateo-Woodburn, 270 Cal.Rptr. at 899-900
[38] *Id.*
[39] *See id.*
[40] *See id.*
[41] Joint Commission On The Accreditation Of Healthcare Organizations, The Accreditation Manual For Hospitals 53 (1993); *See* 42 U.S.C. §§ 1395x(e), 1395bb
[42] Joint Commission On The Accreditation Of Healthcare Organizations, The Accreditation Manual For Hospitals 53 (1993)
[43] *See* 42 U.S.C. §§ 1395x(e), 1395bb
[44] Talking Points: Opposing Economic Credentialing, American Medical Association, (November 2005)
[45] Ga. Comp. R. & Reg. r. 111-2-2-.40; ASC Component Plan, *supra*, note ___, at 11-15
[46] Ga. Comp. R. & Reg. r. 111-2-2-.40(c); ASC Component Plan, *supra*, note ___, at 12

This continuity of care standard requires that each ASC applicant have a medical director that has admitting privileges with a local hospital, and/or the ASC must maintain a hospital affiliate agreement or other documented arrangement to ensure the necessary backup for medical complications.[47] The ability to transfer ambulatory patients to hospitals in both emergent and non-emergent situations is critical to ensuring patient safety and care.[48] Further, this transfer arrangement is in keeping with licensure and accrediting standards which, as discussed, *supra*, are vital to the quality standards for a CON applicant as well as the continued operation of the ASC as a Medicare and Medicaid provider.[49] Therefore, without some form of transfer agreement or the maintained staff privileges of the medical director, the ASC cannot meet the continuity of care or the quality of care CON standards.[50] Effectively, this means the ASC cannot obtain an ASC CON without a local hospital's cooperation.

Further, the ASC must have a transfer agreement and/or the medical director must have privileges at a hospital in order to obtain and maintain a permit from the Georgia Department of Community Health.[51] An ASC cannot operate without a permit and failure to have a transfer agreement or a medical director with admitting privileges is grounds for permit revocation.[52] Of course, pursuant to EMTALA requirements, if a patient from an ASC presents to the hospital, the hospital has a duty to screen and stabilize the patient, or accept the patient as an "appropriate transfer".[53] However, if the ASC's permit is revoked, the ASC must cease operations.[54]

If the hospital is included in the formation of the ASC, the hospital would obviously have a vested interest in providing an affiliate agreement. However, if the hospital is not included, the hospital could refrain from providing an affiliate agreement, or enter into a revocable agreement, thus leaving the ASC at the hospital's mercy in establishing or maintaining staff privileges for the medical director of the ASC. Other ASC staff members may also be hospital staff members; however, the continuity of care standard requires the medical director have admitting privileges if there is no transfer agreement in place.[55] If the wholly physician-owned ASC began "cherry picking" patients for the ASC, and therefore adversely affected the hospital financially, the hospital would be able to take adverse credentialing actions to protect the hospital and the patient care it renders.

Therefore, deregulating the CON process to allow for ASCs does not necessarily mean that hospitals will not have the ability to restrict competition. Georgia law, however, is not particularly clear that hospitals may take this type of credentialing action.[56] Other jurisdictions have established precedent that allows hospitals to take this

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[47] Ga. Comp. R. & Reg. r. 111-2-2-.40(c); ASC Component Plan, *supra*, note ___, at 12
[48] ASC Component Plan, *supra*, note ___, at 12
[49] ASC Component Plan, *supra*, note ___, at 12, 14; Joint Commission On The Accreditation Of Healthcare Organizations, The Accreditation Manual For Hospitals (2006)
[50] *See* Ga. Comp. R. & Reg. r. 111-2-2-.40(c); ASC Component Plan, *supra*, note ___, at 12
[51] Ga. Comp. R. & Reg. r. 290-5-33-.05 (2006)
[52] *See* Ga. Comp. R. & Reg. r. 290-5-33-.05(7); Ga. Comp. R. & Reg. r. 290-5-33-.23 (2006)
[53] 42 U.S.C. § 1395dd.
[54] Ga. Comp. R. & Reg. r. 290-5-33-.06 (2006); The ASC may also lose its accreditation, and there will not be deemed compliant with Medicare and Medicaid provider regulations.
[55] Ga. Comp. R. & Reg. r. 111-2-2-.40(c).
[56] S*ee, e.g.,* Cobb County-Kennestone Hospital Authority v. Prince, 249 S.E.2d 581 (Ga. 1978)

action.[57] Hospitals in Georgia should now lobby for amendments to the current staffing laws to expressly allow for credentialing based on economic criteria.

d. National Economic Credentialing Precedent

Hospital boards have generally been given wide discretion to take administrative actions that restrict physicians' ability to practice.[58] While some hospitals have relied on quality and economic concerns when adopting policies relating to exclusive contracting or closed staffs, at least three courts have upheld a hospital's use of purely economic considerations in denying a physician privileges.[59] Initially, though, the paper will examine a mixed approach found in *Mateo-Woodburn v. Fresno Community Hospital*.[60]

i. *Mateo-Woodburn v. Fresno Community*

The reasoning in *Mateo-Woodburn* provides an example of the how courts have reacted when faced with hospital administrative decisions that adversely impact a physician's privileges.[61] In *Mateo-Woodburn*, the Court of Appeals of California addressed whether a hospital abused its power when deciding to close its anesthesia staff and enter into an exclusive contract for anesthesia services.[62] The hospital was experiencing problems in the department under the anesthesia delivery system that adversely affected the efficient delivery of anesthesia services to patients, lowered the quality of patient care, and created a potential risk to patients.[63] Therefore, the hospital board notified its existing medical staff that it was entering into an exclusive contract with a single anesthesia provider.[64] It further notified the staff that, if they did not enter into contracts with the group, the physicians would not be permitted to engage in direct patient anesthesia care in the hospital.[65] However, at their option, the physicians could retain staff membership and render professional evaluation and assessment of a patient's medical condition at the express request of the attending physician.[66] The contracting physician was required by the employment contract with the exclusive provider to limit his or her professional practice to Fresno Community Hospital.[67]

The California court found that this was a valid exercise of the hospital board's authority.[68] The court noted that "[a]n important public interest exists in preserving a hospital's ability to make managerial and policy determinations and to retain control over the general management of the hospital's business."[69] The court also noted that hospitals are under an obligation to remedy any situation which threatens or jeopardizes patient

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[57] *See e.g. Mahan,* 621 N.W.2d 150; *Mateo-Woodburn*, 270 Cal.Rptr. 894
[58] *See e.g. Mahan,* 621 N.W.2d 150; *Mateo-Woodburn*, 270 Cal.Rptr. 894; Knapp v. Palos Community Hospital, 465 N.E. 2d 554 (Ill. App. Ct. 1984)
[59] *See id.*; Lister v. Methodist Medical Ctr., 1993 Tenn. App. LEXIS 717; Naples Community Hospital v. Hussey, 918 So. 2d 323 (Fla. Dist. Ct. App. 2005); Rosenblum v. Tallahassee Memorial Regional Medical Center, No. 91-589 (Fla. Cir. Ct., June 18, 1992)
[60] *See Mateo-Woodburn*, 270 Cal.Rptr. at 896-900
[61] *See Mateo-Woodburn*, 270 Cal.Rptr. at 896-900
[62] *Id.* at 896
[63] *Id.* at 897
[64] *Id.* at 896
[65] *Id.* at 899
[66] *Id.*
[67] *Id.* at 900
[68] *Id.* at 905
[69] *Id.* at 902

care.[70] Managerial decisions concerning the operation of the hospital are well within the power of the board and will not be overturned unless it clearly appears it is unreasonable, unlawful, or will seriously injure a significant public interest.[71] The hospital may even show bias or prejudice in favor of the selected policy without invalidating the decision.[72] Therefore, the court ruled the hospital's decision to change from an open to a closed system for anesthesia services was not irrational, arbitrary, contrary to public policy or procedurally unfair.[73]

The court in *Mateo-Woodburn* also noted that there is a distinction between a situation where a hospital takes action intentionally directed at the exclusion of a practitioner and one where the action results in the exclusion of a practitioner but is done with less personally directed manner.[74] The court found its situation to be of the latter variety.[75] Further, the hospital's decision was based mostly on quality of care concerns, although the court classifies the decision as administrative in nature.[76]

The process of pulling the privileges of the ASC medical director, as outlined, *supra*, would result in an intentional action directed at the exclusion of the medical director of the ASC. The decision would be based on case-specific facts; however, the decision would be based, at least in part, on economic concerns and not merely quality concerns. Therefore, it is uncertain that the *Mateo-Woodburn* court would uphold such action.[77] However, there is precedent elsewhere that offers a different perspective.[78]

ii. *Mahan v. Avera St. Luke's*

The South Dakota Supreme Court held that a hospital's decision to enter into an exclusive contract for neurosurgical services was a reasonable administrative decision to ensure the economic viability of the hospital.[79] In *Mahan*, local physicians had decided to build a day surgery center that would directly compete with the hospital.[80] The hospital had recently recruited a neurosurgeon that would perform certain spinal procedures similar to those performed at the physicians' surgery center.[81] The board found that a neurosurgeon would not come to the hospital if there were already established orthopedic spine surgeons in the market.[82]

During the first seven months that the surgery center was open, the hospital suffered a significant loss of operating room hours.[83] In response to this, the hospital closed its staff to physicians requesting privileges for three spinal procedures, as well as orthopedic surgery.[84] Thereafter, the surgery center physicians recruited a new physician

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[70] *Id.*
[71] *Id.*
[72] *Id.* at 903
[73] *Id.* at 902
[74] *Id.*
[75] *Id.*
[76] *Id.* at 897
[77] *See id.*
[78] *See Mahan*, 621 N.W. 2d at 160; *Lister*, 1993 Tenn. App. LEXIS 717; Naples Community Hospital v. Hussey, 918 So. 2d 323 (Fla. Dist. Ct. App. 2005); *Rosenblum*, No. 91-589
[79] *Mahan*, 621 N.W. 2d at 160
[80] *Id.* at 153
[81] *Id.*
[82] *Id.*
[83] *Id.*
[84] *Id.*

who, in turn, requested privileges at the hospital.[85] The hospital denied his requests and he brought suit claiming that the action was in breach of the medical bylaws.[86]

The court noted that, under the corporate bylaws, the board has the authority to make decisions without first consulting the medical staff, and is explicitly authorized to make business decisions on behalf of the corporation.[87] The decision by the board was a decision on how to operate a department within the corporation.[88] The court stated that the hospital could not continue to offer unprofitable, yet essential services like the maternity ward, emergency room, pediatrics and critical care units, without the offsetting financial benefit of more profitable areas such as neurosurgery.[89]

The court found that the decision to close the hospital's facility for certain, named procedures was a reasonable administrative decision determined to be necessary to insure the continued viability of the hospital.[90] The court noted that hospitals have legally defined responsibilities and duties to its patients, and therefore must have the power to close its doors to certain physicians.[91] These type decisions must be protected to ensure that the hospital is able to provide care for the community.[92] The hospital determined that it was in the best interests of the community to provide 24-hour neurosurgical services.[93] In order to provide that coverage the hospital needed to recruit neurosurgeons.[94] To recruit the required physicians, the board determined that the staff needed to be closed.[95] The court found that this decision was economically reasonable.[96]

Therefore, the action by the board to close the staff was a reasonable administrative decision compliant with the by-laws.[97] According to *Mahan*, an administrative action based solely on its effect on the economic viability of the hospital is a reasonable exercise of the board's.[98] South Dakota, however, is not alone in this holding.[99]

iii. *Lister v. Methodist Medical Center of Oak Ridge*

The Court of Appeals of Tennessee also held that an administrative decision by a hospital board based solely on the economic affect of the decision is a valid exercise.[100] In *Lister*, the physician was an anesthesiologist with privileges at the hospital.[101] The hospital subsequently entered into an exclusive contract for the provision of anesthesia with a group that did not include the plaintiff physician.[102] The physician sued claiming

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[85] *Id.*
[86] *Id.*
[87] *Id.* at 156
[88] *Id.*
[89] *Id.*
[90] *Id.* at 160
[91] *Id.*
[92] *Id.*
[93] *Id.* at 158
[94] *Id.*
[95] *Id.*
[96] *Id.*
[97] *Id.* at 160
[98] *Id.*
[99] *See Lister*, 1993 Tenn. App. LEXIS 717, *2; *Rosenblum*, No. 91-589
[100] *Lister*, 1993 Tenn. App. LEXIS 717, *2
[101] *Id.*
[102] *Id.*

breach of contract.[103] The parties stipulated that the sole basis of the hospital's decision to enter into the exclusive contract was the economic benefit of such an agreement.[104]

The court held that the hospital's decision to terminate the physician's privileges based solely on business considerations was not contrary to the by-laws, which are considered a contract in Tennessee.[105] The by-laws did not make competency and conduct the exclusive basis for terminating privileges.[106] Moreover, the court recognized that hospital staffing decisions involving specialized medical and business considerations are entitled to deference from the courts.[107] Therefore, the hospital did not breach the physician's contract and was justified in terminating his privileges based solely on the economic benefit of the decision.[108] The Court of Appeals of Florida has recently taken a similar approach.[109]

e. Naples Community Hospital v. Hussey

In *Naples Community Hospital v. Hussey*, the court found that the hospital board did not breach the medical staff bylaws by not renewing a physician's privileges based on a business decision to enter into an exclusive contract.[110] The plaintiff had been a member of the medical staff and had clinical privileges in anesthetic and pain management since 1995.[111] His privileges expired in 1997 and were not renewed by the hospital.[112] Instead, the hospital entered into an exclusive contract for the provision of anesthetic and pain management services.[113] The physician sued claiming breach of contract.[114]

The court recognized that Florida has adopted the majority view that hospital by-laws are binding and are an enforceable contract between the hospital and the medical staff when approved by the governing board of the hospital.[115] Therefore, the court looked to the bylaws to determine whether the hospital had breached any contractual duty owed to the physician.[116] The by-laws provided that staff members reapplying for clinical privileges are subject to a process in which the chairperson of each department makes recommendations based on ethical behavior, competence, attendance and participation at staff meetings, compliance with bylaws and policies, behavior at the hospital, use of the hospital's facilities, ability, capacity to satisfactorily treat patients, satisfaction of continuing education requirements, other relevant findings from the hospital's quality

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[103] *Id.*; Tennessee common law recognizes that physicians have contractual rights created by hospital by-laws. *See* Lewisburg Community Hospital v. Alfredson, 805 S.W. 2d 756 (Tenn. 1991). There is a split of authority between the states as to this principle. *See id.* Georgia does not recognize contractual rights in hospital by-laws. Stein v. Tri-City Hospital, 384 S.E.2d 430, 432-433 (Ga. Ct. App. 1989).
[104] *Lister*, 1993 Tenn. App. LEXIS 717, *2
[105] *Id.* at *5
[106] *Id.*
[107] *Id.* at *3 (citing *Lewisburg*, 805 S.W. 2d 756)
[108] *Id.* at *5
[109] *See* Naples Community Hospital v. Hussey, 918 So. 2d 323 (Fla. Dist. Ct. App. 2005)
[110] *Id.* at 324
[111] *Id.*
[112] *Id.*
[113] *Id.*
[114] *Id.*
[115] *Id.* at 325
[116] *See id*.

assessment activities, peer recommendations concerning skills, and board certification status.[117]

However, the court noted that the by-laws did not expressly state whether a staff member who is reapplying for clinical privileges in an area under an exclusive contract is subject to the same process.[118] The court suggested that the process of review by the chairpersons, when applied to the instant situation, would be futile because the hospital would be denying renewal of such clinical privileges based on a business decision to enter into an exclusive contract, and not because of recommendations from department chairpersons.[119] The doctor's competence had not been called into question and his or her reputation was not at stake.[120]

The court held that the hearing process described in the by-laws clearly did not apply to this situation.[121] Therefore, the hospital board's decision to deny the physician privileges based on a business decision to exclusively contract with another provider was a valid exercise of its authority.[122]

Similar to the Tennessee and South Dakota courts, this court was faced with a claim of breach of contract claim arising out of a violation of procedures outlined in the hospital by-laws.[123] Therefore, the courts arguably were merely construing contracts and were not focused on solely the hospitals' actions.[124] However, not every state recognizes that hospital by-laws create contract rights for physicians.[125]

The paper now turns to analyze how Georgia, a state that does not recognize that contract rights are created by a hospital's by-laws, treats these credentialing decisions based on economic factors.

f. Georgia Economic Credentialing Precedent

In Georgia, it is unclear whether the use of economic criteria in the credentialing process could legally be used to combat any ill affects caused by deregulating the CON process. Physicians might be dissuaded from competing with hospitals by the threat of economic credentialing; however, whether economic credentialing is allowable in Georgia is far from being definitively decided. Suffice to say, there are numerous hurdles the hospital board must jump through in order to take adverse credentialing action. Even if the process outlined at common law is followed, the hospital may find itself not only dealing with the necessary legal repercussions, but also with an unhappy medical staff. Regardless, the rationale to justify this action has been expressed in Georgia courts and arguably in the staffing statute itself.

Similar to other jurisdictions, Georgia courts have recognized that the state has a duty to monitor the provision of healthcare in order to protect the health and welfare of its citizens.[126] The preservation of public health is one of the duties devolving on the state as the sovereign power, and the discharge of this duty is accomplished by means of the

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[117] *Id.* at 326
[118] *Id.*
[119] *Id*.
[120] *Id.*
[121] *Id.* at 327
[122] *See id.*
[123] *Compare id.* at 324, *with Lister*, 1993 Tenn. App. LEXIS 717, *2, *and Mahan*, 621 N.W. 2d at 156
[124] *Compare id.* at 324, *with Lister*, 1993 Tenn. App. LEXIS 717, *2, *and Mahan*, 621 N.W. 2d at 156
[125] *See, e.g.,* Stein v. Tri-City Hospital, 384 S.E.2d 430, 432-433 (Ga. Ct. App. 1989)
[126] *Cobb County-Kennestone*, 249 S.E.2d 581

exercise of the inherent police power of the sovereign.[127] Courts believe, as a result, the legislature has seen fit to endow both physician and hospital with certain rights and restrictions in order to protect citizens in the exercise of this essential health function.[128] Each party exercises exclusive of the other, although each has areas of responsibility in the treatment and diagnosis of patients.[129] One such area for hospitals is the responsibility to render decisions in regards to the administration, operation, maintenance and control of the hospital.[130] Georgia public hospitals have an obligation to operate in such a way as to promote optimal patient care and to assure the hospital's financial well being.[131] Hospitals meet this obligation, in part, by properly credentialing their physicians.[132] Traditionally, Georgia courts have shown deference to both public and private hospital boards when administrative decisions affecting a physician's privileges have been questioned.[133]

Georgia statutes do not address what criteria private hospitals must use when granting or revoking privileges. However, a public hospital may consider the following when determining whether to grant staff privileges to a physician: the applicant's demonstrated training, experience, competence, and availability and reasonable objectives, including, but not limited to, the appropriate utilization of hospital facilities.[134] Moreover, a public hospital authority has the ultimate power to manage and operate the hospital.[135]

i. *Cobb County-Kennestone Hospital Authority v. Prince*

In 1978, the Supreme Court of Georgia held that a challenged resolution passed by a public hospital authority restricting its patients from utilizing off-site diagnostics when those same diagnostics are offered at the hospital was a reasonable and rational administrative decision enacted in order for the authority to carry out its legislative mandate to provide adequate medical care in the public interest.[136] The litigation began after five members of the medical staff at Kennestone Hospital approached the hospital regarding their potential purchase of a computer assisted tomoscope (C.A.T.).[137] The physicians proposed that they be allowed to lease space at the hospital in order to operate the machine.[138] The authority rejected the proposal citing their policy against leasing space at the hospital to for profit enterprises, but indicated that the hospital would

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[127] *Id*.
[128] *Id*. at 584
[129] *Id*.
[130] *See id.* at 585-586
[131] Alonso v. Hospital Authority of Henry County, 332 S.E.2d 884 (Ga. Ct. App. 1985) (holding that a physician's refusal to renegotiate his contract to allow for maximum allowable reimbursement under new Medicare and Medicaid payment systems provided the public hospital with just cause in terminating his contract)
[132] *See Cobb County-Kennestone*, 249 S.E.2d at 585
[133] *See, e.g.,* Dunbar v. Hospital Authority of Gwinnett County, 182 S.E.2d 89 (Ga. 1971); *Cobb County-Kennestone*, 249 S.E.2d at 581; Whitaker v. Houston County Hospital Authority*,* 613 S.E.2d 664 (Ga. Ct. App. 2005).St. Mary's Hospital of Athens v. Radiology Professional Corp., 421 S.E.2d 731 (Ga. Ct. App. 1992); Stein v. Tri-City Hospital, 384 S.E.2d 430, 432-433 (Ga. Ct. App. 1989); Alonso v. Hospital Authority of Henry County, 332 S.E.2d 884 (Ga. Ct. App. 1985)
[134] Ga. Code Ann. §31-7-7 (2006)
[135] Ga. Code Ann. §31-7-75 (2006)
[136] *Cobb County-Kennestone*, 249 S.E.2d at 588
[137] *Id*. at 582-583
[138] *Id*. at 583

consider providing these services if the need was apparent.[139] The authority offered a counter-proposal that the hospital would lease the machine from the physicians enabling the hospital to place the machine on its premises without violating the authority's policy.[140] The physicians rejected the counter-proposal and instead began negotiations to purchase the machine and locate it outside of the hospital complex.[141]

The hospital sought and was granted approval for the purchase of a C.A.T. machine.[142] The hospital then issued a memorandum to all medical staff members announcing its intent to purchase the machine.[143] Thereafter, the five physicians finalized negotiations for the purchase of their machine.[144] Prior to the physicians' machine becoming operational, the authority passed a resolution stating that "[i]t is the general policy of Kennestone Hospital that if a treatment, procedure, diagnostic test or other service is ordered for a patient of Kennestone Hospital, and that procedure, test or service is routinely offered by the Hospital, then the patient will receive that service within the confines of the Hospital complex."[145] The hospital gave the following reasons for adopting the resolution: (1) to eliminate inconvenience and confusion to the patients; (2) to avoid the potential of jeopardizing the seriously ill patients by transferring them outside the hospital; (3) to preclude undue expense accruing to the patient; (4) to reduce the potential of unnecessary liability to the hospital and physicians; and (5) to insure continuation of the hospital's ability to provide proper service and facilities.[146] Because of the physicians' machine was operable first, in-patients were initially allowed to be transported to the off-site scanner.[147] However, when the hospital's scanner became operational, this practice was stopped.[148]

Thereafter, the physicians continued to refer patients to their off-site facility.[149] The hospital informed the physicians of their violations of hospital policy and that continued violations would result in the reconsideration of their medical staff privileges.[150] The physicians then filed suit seeking equitable relief and damages alleging that the resolution was void and of no effect in that it was arbitrary and unreasonable.[151]

The court found that the resolution was an administrative policy adopted pursuant to the power vested in the authority by the legislature in furtherance of the administration, operation, maintenance and the control of the hospital, and, unless it was unreasonable or arbitrary, it was a valid exercise of that authority.[152] Although this was an issue of first impression, the court found persuasive that other jurisdictions have upheld a hospital's decision requiring in-patients to receive services from one physician or group of

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[139] *Id*.
[140] *Id*.
[141] *Id*.
[142] *Id*.
[143] *Id*.
[144] *Id*.
[145] *Id*.
[146] *Id*. at 584
[147] *Id*. at 583-584
[148] *Id*. at 584
[149] *Id*.
[150] *Id*.
[151] *Id*.
[152] *Id*. at 585-586

physicians to the exclusion of other medical-staff members.[153] Practical considerations of hospital operation permit hospital administrators to conclude that specialty services can best be provided by entering into exclusive medical service contracts.[154] The court found that the resolution reflected a well intentioned effort by the hospital to deal with the intricate and complex task of providing comprehensive medical services to the citizens of Georgia.[155] Therefore, the court found the hospital's resolution to be a reasonable and rational administrative decision.[156]

The reasons expressed in the decision provide the basis for Georgia public hospitals' ability to make decisions based in part on economic factors. The Court recognized the importance of maintaining a hospital's administrative decision making power so that they may meet their duty to provide healthcare services to the general public.[157] This power is an intricate part of a public hospitals' ability to provide healthcare in the community.[158] However, Georgia courts have not limited the power derived from the public hospital staffing statutes to public hospitals.[159]

ii. *St. Mary's Hospital of Athens v. Radiology Professional Corp.*

The Georgia Court of Appeals more recently addressed a similar situation for a private non-profit hospital in *St. Mary's Hospital of Athens, Inc. v. Radiology Professional Corporation*.[160] In this case, the court found that St. Mary's hospital had the authority to enter into exclusive contracts for services in a given specialty or area of practice and that such authority included the concomitant right to terminate staff privileges to maintain this exclusivity.[161] St. Mary's granted Dr. Cohen privileges in the 1960's.[162] In 1971, the hospital entered into an exclusive contract for radiological services with Radiology Professional Corporation (hereinafter R.P.C.) owned by Dr. Cohen.[163] The contract provided that either party could terminate the contract without cause upon giving the requisite notice to the other party. [164] This litigation arose when St. Mary's attempted to terminate its contract with the R.P.C and terminate Dr. Cohen's privileges.[165]

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[153] *Id*. at 587 (citing Radiology Professional Corp. v. Trinidad Area Health Assn., 577 P.2d 748 (Colo. 1978) (holding that limiting a physician's privileges by entering into exclusive contracts is a valid administrative power for a hospital board);); Adler v. Montefiore Hospital Assn. of W. Pa., 311 A.2d 634 (Pa. 1973) (holding a regulation restricting access to cardiac catheterization equipment was a reasonable rule intended alike for the benefit of patients and their doctors and the hospital and the public it serves); Benell v. City of Virginia, 104 NW2d 633 (Minn. 1960) (holding that a resolution granting exclusive use of an x-ray machine was not arbitrary or unreasonable and was an administrative action in furtherance of the operation and control of the hospital))

[154] *Id*. at 147 (citing Radiology Professional Corp. v Trinidad Area Health Asc., Inc., 195 Colo. 25, 577 P.2d 748 (1978)

[155] *Id*. at 588

[156] *Id*.

[157] *See id.* at 587-588 (citing Adler, 311 A.2d 634, and stating that the authority was carrying out a legislative mandate to provide adequate medical care in the public interest)

[158] *See id.*

[159] *See St. Mary's*, 421 S.E.2d 731

[160] *Id.*

[161] *Id*. at 737

[162] *Id*. at 733

[163] *Id*.

[164] *Id*.

[165] *Id*. at 734

The court reiterated that the hospital administrators had broad authority to make decisions and implement policies concerning the administration, operation, maintenance, and control of the hospital and the management and treatment of patients.[166] Therefore, the decision to terminate the exclusive contract with the R.P.C. was a valid action taken pursuant to that authority and, with appropriate notice, valid under the contract.[167] Further, the court ruled that the hospital had the authority to terminate Dr. Cohen's medical staff privileges in order to maintain its exclusive service arrangement.[168]

Therefore, it seems as though Georgia courts have confirmed that both public and private hospital boards have the ability to make decisions based, in part, on the financial best interests of the hospital. However, each of these cases has involved exclusive contract situations.[169] Although it seems clear that hospitals can enter into exclusive contracts for services based on the financial impact of the decision, it remains unclear whether these hospital boards could refuse or revoke a physician's privileges, without entering into or terminating exclusive contracts, based solely on the economic impact of the decision.

The paper will discuss, *infra*, how the General Assembly could make this issue more lucid, but first, the paper must address other concerns surrounding the utilization of economic credentialing to provide a basis for the inclusion of certain language necessary to protect Georgia hospitals' ability to use this theory. There are three main areas of concern hospital boards should be cognizant of when attempting to utilize economic criteria in an adverse credentialing decision: due process, antitrust, and federal fraud and abuse laws.

g. Due Process Concerns

Physicians are entitled to due process when first obtaining privileges at a public hospital.[170] Further, they should be afforded notice and a hearing before the hospital authority and not just the medical staff.[171] However, when a hospital is attempting to terminate the privileges of a physician already on the staff, the analysis changes somewhat. The *St. Mary's* case provides an overview of the due process analysis for both public and private hospitals.[172]

In *St. Mary's*, the Court ruled that, although the hospital had the authority to terminate privileges, this right could not be exercised in a manner inconsistent with the medical staff bylaws.[173] Dr. Cohen argued that terminating his medical staff privileges was a tortious denial of due process rights contractually guaranteed.[174] The Court interpreted this as being a claim under three possible causes of action: 1) a deprivation of liberty or property rights without due process of law, 2) a breach of a contractual obligation to comply with the bylaws, or 3) a tortious violation of a legal duty, arising independently of the contract, to comply with the bylaws.[175]

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[166] *Id*
[167] *Id*.
[168] *Id*. at 737
[169] *See id.* at 731; *Cobb County-Kennestone*, 249 S.E.2d at 585
[170] Shaw v. Hospital Authority of Cobb County, 507 F.2d 625, 628 (5th Cir.) (1975)
[171] *Id*.
[172] *See St. Mary's*, 421 S.E.2d at 735-737
[173] *St. Mary's*, 421 S.E.2d at 737
[174] *Id*. at 735
[175] *Id*.

i. Deprivation of Liberty or Property without Due process

In regards to the first cause of action, the Court noted that the due process clauses of the United States and Georgia Constitutions control the actions of governments, not those of private individuals.[176] Because St. Mary's was a private hospital, and no nexus between the State and the termination by St. Mary's of Cohen's staff privileges existed, Dr. Cohen could not maintain a cause of action for a deprivation of liberty or property without due process.[177]

However, public hospitals are subject to the due process clauses of Georgia and the United States, and therefore may be liable under 42 U.S.C. § 1983.[178] In order to maintain a due process claim, the physician must demonstrate that the hospital deprived him of a constitutionally protected property or liberty interest.[179] Basically, the claim must be supported by some state statute, legal rule, or a mutually explicit understanding.[180] To establish a protected property interest in medical staff privileges, a physician must allege injury to a contract right or an inability to practice medicine without the requested privileges.[181] For those providers with exclusive contracts, this is an easy analysis.[182] Otherwise, the court must analyze the decisions affect on the physician's ability to maintain its practice.[183]

If the denial of staff privileges does not seriously foreclose the ability of a physician to engage in private practice, then the physician does not satisfy his burden of presenting facts to show that a property interest existed.[184] The denial of staff privileges to a physician in private practice means that the physician cannot have his patients admitted to the denying hospital; thus, denial of staff privileges may seriously limit his opportunity to engage in private practice.[185] Therefore, due process must be given.[186]

The extent of the due process depends on the situation.[187] Due process protection is significantly less when the right to perform a particular medical service is restricted in some manner, but medical staff privileges are not completely terminated or withdrawn.[188] Regardless, to attempt to comply as fully as possible, hospital boards should at least afford notice and hearing for both medical staff committee decisions and the ultimate hospital board decisions.[189]

ii. Contractual Due Process

As for the claim for breach of contract for noncompliance with the bylaws, the *St. Mary's* court stated that hospitals have the authority to establish and revise rules and regulations governing the appointment of physicians to the hospital staff.[190] Medical staff

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[176] *Id*. at 735-736
[177] *Id*. at 736
[178] *See* Todorov v. DCH Healthcare Authority, 921 F.2d 1438, 1462 (11th Cir. 1991)
[179] *Id.*
[180] *Id.* at 1463 (citing Perry v. Sindermann, 408 U.S. 593, 601-602 (1972))
[181] *Id.* (citing Shahawy v. Harrison, 778 F.2d 636, 642 (11th Cir.1985))
[182] *See* Northeast Georgia Radiological Asc. V. Tidwell, 670 F.2d 507, 511 (M.D. Ga. 1982)
[183] *See* Todorov, 921 F.2d at 1464
[184] Todorov, 921 F.2d at 1464 (citing Burkette v. Lutheran Gen. Hosp., 595 F.2d 255, 256 (5th Cir.1979))
[185] Burkette, 595 F.2d at 256
[186] *See id.*; Todorov, 921 F.2d at 1464; Shahawy, 778 F.2d at 642
[187] *See* Bellam v. Clayton County Hospital Authority, 758 F.Supp. 1488, 1492 (N.D. Ga. 1990)
[188] Bellam, 758 F.Supp. at 1492
[189] Shaw, 507 F.2d at 627
[190] *St. Mary's*, 421 S.E.2d at 736

bylaws alone do not create any contractual right to continuation of staff privileges.[191] Further, hospitals are entitled to change the staff bylaws or the terms of appointment even if that act results in the termination of a physician's staff privileges.[192] Therefore, the Court ruled that no cause of action lies against a hospital ex contractu based solely on the alleged breach of the medical staff bylaws.[193] The court inferred, however, that the decision may have been different if Dr. Cohen had a contract expressly incorporating the staff bylaws or otherwise contractually providing that Cohen's privileges could be terminated only in accordance with the procedures set forth in the bylaws.[194]

iii. Tortious Violation of a Legal Duty

Under the third cause of action, the *St. Mary's* court held that, pursuant to Georgia law, the hospital could be held liable for tort damages if Dr. Cohen's staff privileges were terminated without complying with the provisions of the staff bylaws concerning notice and a hearing.[195] Georgia law provides that when the law requires a person to perform an act for the benefit of another or to refrain from doing an act which may injure another, although no cause of action is given in express terms, the injured party may recover for the breach of such legal duty if he suffers damage thereby.[196]

The court stated that, although a physician has no absolute right to practice in a given public hospital, the physician is entitled to practice in public hospitals as long as he complies with applicable laws, rules, and regulations.[197] Such privileges may not be deprived by rules or acts that are unreasonable, arbitrary, capricious, or discriminatory.[198] Notwithstanding the broad power of a hospital authority to control the administrative, operational, and managerial functions of the facility and its staff, a public hospital authority cannot abridge or refuse to follow its existing bylaws concerning staff privileges.[199] While the hospital has broad authority to change the bylaws, it cannot refuse to follow existing bylaws.[200] Doing so is a violation of a legal duty, and therefore is actionable under section 51-1-6.[201]

Therefore, the Court held that physicians may assert a cause of action in tort against hospitals for failure to follow existing bylaws with regard to termination of staff privileges.[202] This is true for public as well as private hospitals.[203]Accordingly, Dr. Cohen, as a member of the medical staff, should have been afforded the due process protections provided for in the staff bylaws.[204] In order for the hospital to protect the right to maintain exclusivity through termination of staff privileges, the hospital must have outlined this right either in the staff bylaws or in the contract with the individual

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[191] *Id*.
[192] *Id*.
[193] *Id*.
[194] *Id*.
[195] *Id*. at 736-737
[196] Ga. Stat. Ann. § 51-1-6 (2006)
[197] *St.Mary's*, 421 S.E.2d at 736
[198] *Id*.
[199] *Id*. at 737
[200] *Id*.
[201] *Id*.; *See* Ga. Stat. Ann. § 51-1-6
[202] *St.Mary's*, 421 S.E.2d at 737
[203] *Id*.
[204] *Id*.

physician.[205] In this case, there was no contract between the physician and the hospital and the bylaws did not expressly give this right to the board.[206]

Therefore, according to *St. Mary's*, the hospital must follow the medical staff bylaws and whatever procedural safeguards they contain in order to revoke a physician's privileges.[207] Further, the right to revoke a physician's privileges for economic reasons must be outlined in the bylaws.[208] If the bylaws do not so provide, the hospital may amend the medical staff bylaws even if doing so would result in the termination of staff privileges.[209] This detailed process was reiterated in a more recent Georgia case.[210]

iv. *Satilla Health Services v. Bell*

In *Satilla Health Services v. Bell*, the court stressed that the board should be concerned with the due process rights of the physician when proceeding with adverse credentialing decisions.[211] This case involved a private non-profit hospital attempting to change from one exclusive provider of cardiovascular services, SGCA, to another.[212] Prior to entering into the exclusive contract with SGCA, the doctors comprising SGCA were on the medical staff of the hospital.[213] The doctors maintained their privileges throughout the exclusive contract period.[214]

Thereafter, the hospital terminated the contract and entered into a contract with another cardiovascular group, Baptist Specialty.[215] The hospital notified the SGCA physicians that their privileges were terminated because of the termination of the contract.[216] The SGCA physicians sought an injunction prohibiting the hospital from limiting their practice at the hospital.[217] The hospital then adopted a resolution providing that only those physicians employed by or under contract with Baptist Specialty would be entitled to use the facilities for cardiology privileges as long as the exclusive contract was in effect.[218] It also provided that the action taken did not constitute a revocation or termination of privileges of the affected physicians.[219]

The hospital was apparently attempting the same strategy found in *Mateo-Woodburn*, discussed, *supra*.[220] The Georgia Court found that the hospital had the authority to terminate the SGCA contract and enter into an exclusive contract with Baptist Specialty, but, contrary to the California court finding in *Mateo-Woodburn*, by denying the physicians access to the hospital facilities, the hospital was effectively terminating their privileges.[221] Therefore, as discussed, *supra*, the hospital must have

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[205] *Id*.
[206] *Id*.
[207] *See id.*
[208] *See id.*
[209] *See id.*
[210] Satilla Health Services v. Bell, 633 S.E.2d 575 (Ga. Ct. App. 2006)
[211] *Id.*
[212] *Id*. at 125
[213] *Id*.
[214] *Id*.
[215] *Id*.
[216] *Id*.
[217] *Id*.
[218] *Id*. at 126
[219] *Id*.
[220] *See Mateo-Woodburn*, 270 Cal.Rptr. at 894 (1990)
[221] *Satilla*, 280 Ga. App. at 131

abided by the medical staff bylaws and should have afforded the physicians due process in compliance with the procedural protections afforded to physicians in *St. Mary's*.[222] Accordingly, the hospital would be entitled to automatically terminate the physicians' privileges by way of its resolution only if it reserved the right to do so in the bylaws or in individual contracts with the Doctors, or, alternatively, if the Doctors acquiesced and waived their right to challenge an automatic termination of their privileges.[223]

But due process is not the only problem hospitals should be aware of when implementing an economic credentialing decision. Whereas the procedural process the hospital takes in rendering its decision may create a valid cause of action, the substantive effect of the decision may also be questioned under antitrust analysis.

h. Antitrust Concerns

Section 1 of the Sherman Antitrust Act provides that every contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several states, or with foreign nations, is declared to be illegal.[224] Even where a single firm's restraints directly affect prices and have the same economic effect as concerted action might have, there can be no liability under section 1 in the absence of agreement.[225] Actions of individual doctors on peer review committees are considered actions of the hospital because of the control exercised by the hospital board over peer review decisions and the statutory context of peer review in Georgia.[226] A hospital and its staff can be separate entities in some instances, but the staff physicians may in certain contexts be agents of the hospital for purposes of state action immunity.[227]

But even if the medical staff committee and the board are not seen as a single entity, as long as there is a plausible, pro-competitive explanation for the actions, no violation has occurred.[228] Preserving the efficient operation of a hospital department is an example of one such explanation.[229] Moreover, the board will usually be acting unilaterally without the aid of the medical staff committee in the situations applicable to this paper's discussion; therefore, no conspiracy could be found.[230]

Section 2 of the Sherman Antitrust Act provides that every person who shall monopolize, or attempt to monopolize, or combine or conspire with any other person or persons, to monopolize any part of the trade or commerce among the several States, or with foreign nations, shall be deemed guilty of a felony.[231] Section 2 imposes liability on both concerted and unilateral acts.[232]

i. State Action Immunity

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[222] *Id*.
[223] *Id*.
[224] 15 U.S.C. § 1 (2006)
[225] Fisher v. City of Berkeley, 475 U.S. 260, 266 (1986)
[226] *Crosby*, 93 F.3d at 1530; *But see* Bolt v. Halifax Hosp. Medical Ctr., 891 F.2d 810, 819 (11th Cir. 1990) (holding hospitals and members of its medical staff are separate legal entities, and therefore may be liable under section 1 of Sherman Antitrust Act); Oksanen v. Page Memorial Hosp., 945 F.2d 696, 699 (4th Cir. 1991) (holding that the hospital board and the medical staff are a single entity)
[227] *Crosby*, 93 F.3d at 1530 (distinguishing *Torodov* because it involved the actions of physicians who testified before the peer review committee and were not acting as part of the review committee)
[228] *Torodov*, 921 F.2d at 1456
[229] *Id.*
[230] *Id.* at 1459
[231] 15 U.S.C. § 2 (2006)
[232] See, e.g., Copperweld Corp. v. Independence Tube Corp., 467 U.S. 752 (1984)

Under the state action immunity doctrine, states are immune from federal antitrust law for their actions as sovereign.[233] A municipality is entitled to state action immunity if it acted pursuant to clearly articulated and affirmatively expressed state policy.[234] Therefore, most public hospitals in Georgia cannot be held liable for antitrust violations because Georgia's hospital authorities are political subdivisions for state action immunity purposes.[235] However, the analysis is not the same for private hospitals.[236]

Private parties can claim state-action immunity from Sherman Act liability only when their anticompetitive acts were truly the product of state regulation.[237] The Supreme Court has established a two-pronged test to determine whether anticompetitive conduct engaged in by private parties should be deemed state action and thus shielded from the antitrust laws.[238] First, the challenged restraint must be one clearly articulated and affirmatively expressed as state policy.[239] Second, the anticompetitive conduct "must be actively supervised by the State itself.[240]

The first prong maybe satisfied by an expression of such in a statute.[241] In regards to the second prong, the Supreme Court has held that "the State does not actively supervise [the termination of hospital staff privileges] unless a state official has and exercises ultimate authority over private privilege determinations."[242] A state official has this kind of authority only if he or she has power to review private peer-review decisions and overturn a decision that fails to accord with state policy.[243] Georgia's staffing statute is specifically aimed at public hospitals and there is no corresponding statute for private hospitals.[244] Therefore, in order for private hospitals to be able to effectively utilize economic credentialing, Georgia's staffing statute should be amended.

ii. HCQIA Immunity

It should be noted that the hospital board and medical staff committee actions might be entitled to immunity from damages under the Health Care Quality Improvement Act (HCQIA).[245] Those participating in professional review actions are immunized from damages.[246] However, the situation must meet four conditions: (1) the action was taken in the reasonable belief that it furthered quality health care; (2) the action was taken after a reasonable effort to obtain the facts of the matter; (3) adequate notice and hearing are provided to the physician; and (4) the action was warranted by the facts.[247] However, a

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[233] Parker v. Brown, 317 U.S. 341, 351-53 (1943); FTC v. Hospital Board of Directors of Lee County, 38 F.3d 1184, 1187 (11th Cir.1994)
[234] Town of Hallie v. City of Eau Claire, 471 U.S. 34, 46-47, 105 (1985)
[235] *See* Crosby v. Hospital Auth., 93 F.3d 1515, 1530 (11th Cir. 1996); Every hospital authority shall be deemed to exercise public and essential governmental functions. Ga. Code Ann.§ 31-7-75 (2006)
[236] *See* Patrick v. Burget, 486 U.S. 94, 99-102 (1988)
[237] *Id.* at 100
[238] *See* California Retail Liquor Dealers Assn. v. Midcal Aluminum, Inc., 445 U.S. 97, 105 (1980).
[239] *Id.* at 105 (citing Lafayette v. Louisiana Power & Light Co., 435 U.S. 389, 410 (1978))
[240] *Id.*
[241] *Hallie*, 471 U.S. at 40-42
[242] *Patrick*, 486 U.S. 94
[243] *Id.*
[244] Ga. Code Ann. § 31-7-7
[245] *See* 42 U.S.C. § 11101 *et seq.* (2006); Bryan v. James E. Holmes Regional Medical Ctr., 33 F.3d 1318, 1334 (11th Cir. 1994)
[246] 42 U.S.C. § 11111(a)(1)
[247] 42 U.S.C. § 11112(a)(1-4)

recent opinion in a Georgia District Court held that an adverse credentialing decision against a physician who was competing with the hospital for nephrology services was not made with a reasonable belief that the action was in furtherance of quality health care, was not taken after a reasonable effort to obtain the facts of the situation, and was not warranted by the facts.[248] This holding was a ruling on a motion to dismiss, and therefore, the court was accepting the facts alleged in the complaint and was construing all reasonable inferences in favor of the plaintiff.[249]

In sum, any proposed legislation must take into account the anticompetitive implications of economic credentialing under antitrust laws. Not doing so would potentially spell disaster for hospital boards attempting to apply economic factors in the credentialing process. Nonetheless, there are additional concerns that also must be addressed prior to outlining such a proposal. Economic credentialing could also pose problems under federal fraud and abuse laws.

i. Federal Anti-kickback Statute

Not only should the hospital be concerned about private litigation, but the Federal government may also have a cause of action relating to the use of this administrative power. The federal anti-kickback statute may also dissuade hospitals from exercise this administrative power.[250] The AMA argues that exclusive contracting based on economic criteria violates the federal anti-kickback statute.[251] The Office of the Inspector General (OIG) at the Department of Health and Human Services (HHS) states that conditioning privileges on a particular number of referrals or requiring the performance of a particular number of procedures, beyond volumes necessary to ensure clinical proficiency, potentially raise substantial risks under the statute.[252]

However, a credentialing policy that categorically refuses privileges to physicians with significant conflicts of interest would not appear to implicate the statute in most situations.[253] Therefore, although hospitals should be aware that abuse of this power could implicate the anti-kickback statute, credentialing decisions made with the intent to improve quality of care should fall outside of the anti-kickback statute.[254] Whether a particular credentialing policy runs afoul of the anti-kickback statute would depend on the specific facts and circumstances, including the intent of the parties.[255]

Once again, though, this seems very risky for a hospital. Persons found to be in violation of the Anti-kickback statute are guilty of a felony and are subject to fines up to $25,000 per offense or five years in prison, or both.[256] However, the possibility of civil money penalties from the OIG and possible exclusion from federal healthcare programs

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[248] Wood v. Archbold Memorial Medical Ctr., 2006 U.S. Dist. LEXIS 44292, *8-9 (June 29, 2006)
[249] *Id.* at *5 (citing Kirby v. Siegelman, 195 F.3d 1285, 1289 (11th Cir. 1999))
[250] 42 U.S.C. § 1320a-7b (b)
[251] Letter from Michael D. Maves, American Medical Association, to Kevin G. McAnaney, Chief, Industry Guidance Board, Department of Health and Human Services, Office of Counsel to the Inspector General (September 30, 2002) (available at http://www.ama-assn.org/ama/pub/category/10303.html)
[252] 70 FR 4858, 4869 (2005)
[253] *Id*.
[254] *Id.*
[255] *Id*.
[256] 42 U.S.C. § 1320a-7b (b)

maybe even more discouraging.[257] Therefore, the proposed staffing statute must also address the federal fraud and abuse concerns to help alleviate this problem.

j. Amending the staffing laws

Amending the hospital staffing statute could solidify Georgia hospitals' ability to effectively utilize economic credentialing as part of their administrative power. A statute of this nature would face stiff opposition from physicians throughout the state. Some states have begun taking action to restrict the use of economic credentialing.[258] However, it could be argued that the General Assembly has already expressed this intent into the public hospital statute.[259] Thus, an amendment may have a small chance of passing legislative scrutiny.

Georgia's staffing laws state that a public hospital may consider the following when determining staffing privileges: the applicant's demonstrated training, experience, competence, and availability and reasonable objectives, including, but not limited to, the appropriate utilization of hospital facilities.[260] What constitutes "reasonable objectives" is subject to interpretation; however, it could arguably include protecting the hospital from competitive conflicts of interest.

The phrase "appropriate utilization of hospital facilities" is also subject to interpretation, although, as mentioned, *supra*, note 28, Georgia courts have held that this phrase evidences the legislature's intent to give hospital boards power to become involved in anticompetitive conduct.[261] Further, this language mirrors that in the North Carolina staffing law that courts have held conferred anticompetitive power.[262] A physician that has a tendency to send his less profitable patients to the community hospital, while referring his more profitable patients to the specialty hospital, may not be appropriately utilizing the hospital facilities. If the hospital can adequately prove this tendency during its hearing process, restricting privileges may be allowable under the statute. Of course, as mentioned, this determination will most likely be reviewed in the judicial system and therefore cost the hospital money.

However, if the statute were amended to include private hospitals and a more expansive definition of what constitutes "reasonable objectives" or what is meant by "the appropriate utilization of hospital facilities", this would lessen the chance of litigation in regards to adverse credentialing actions. The expansive definition may include language that would make it more palatable under fraud and abuse laws; stating that "reasonable objectives" includes thwarting significant conflicts of interest.

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[257] *See* 42 U.S.C. § 1320a-7a (2006); 42 U.S.C. § 1320a-7 (2006)

[258] *See* Cal. Bus. & Prof. Code § 2282.5 (establishing medical staff rights to self governance including the right to establish criteria and standards for staff membership and privileges)

[259] *See Craig W. Dallon, Understanding Judicial Review of Hospital's Physician Credentailing and Peer Review Decisions*, 73 Temp. L. Rev. 597 (2000) (stating that the phrase "efficient and effective utilization of hospital resources" in Indiana's staffing statute, Ind. Code Ann. 16-21-2-5(3)(c), as evidence of a jurisdiction permitting economic credentialing in at least some instances); *compare* Ind. Code Ann. 16-21-2-5 *to* Ga. Code Ann. §31-7-7 (2006); *Crosby v. Hospital Authority of Lowndes*, 873 F.Supp. 1568, 1579 (1995) (citing *Coastal Neuro-Psychiatric Asc. v. Onslow Memorial Hosp.*, 795 F.2d 340 (4th Cir. 1986) (determining foreseeability of anticompetitive conduct in context of N.C. Gen. Stat. §131E-85(a) based on "appropriate utilization of hospital facilities")).

[260] Ga. Code Ann. §31-7-7 (2006)

[261] *Sweeney v. Athens Regional Medical Center*, 705 F.Supp. 1556, 1563 (M.D. Ga. 1989);

[262] *Coastal Neuro-Psychiatric*, 795 F.2d at 342

Further, the legislation should address the two prongs of the state immunity test for private parties in order to avoid antitrust problems. First, to more clearly express the legislature's intent to promote the anticompetitive, the statute could add "even if such decision has anticompetitive impacts." Lastly, to address prong two of the state immunity test, the statute should also provide for review of the decisions by a state agency.

Finally, similar to the Florida staffing statute, the statute should also include in its criteria "by such other elements as determined by the governing board" to more clearly express the legislature's willingness to give hospital boards wide latitude in rendering credentialing decision.[263]

k. Conclusion

The proposal outlined herein could be an opportunity for both physicians and hospitals to preview what would happen if the CON program is eliminated. This proposal would create competition by deregulating the CON laws thus allowing limited physician-owned ASCs subject to quality and access determinations. Hospitals could seek to recapture some of the lost revenues from the competing ASC by forming ancillary joint ventures with the physicians. Further, through amending staffing laws to expressly allow economic credentialing, hospitals could remain certain that the physician ASCs do not begin utilizing improper patient selection techniques. Overall, this proposal would bring about greater competition while enhancing quality, access, and convenience.

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[263] *See* Fla. Stat. § 395.0191 (2006) (stating that an applicant's eligibility for staff membership or clinical privileges shall be determined by the applicant's background, experience, health, training, and demonstrated competency; the applicant's adherence to applicable professional ethics; the applicant's reputation; and the applicant's ability to work with others and by such other elements as determined by the governing board)