Georgia's Certificate of Need:
The Effect of Physician-Owned Facilities on Georgia's Next Health Care 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, treating fewer Medicaid patients, failing to provide emergency services, and concentrating on certain highly-reimbursed diagnosis related groups (DRGs), these specialty hospitals are maximizing profit at the expense of general hospitals.[2]

At the same time, Georgia's health care 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, 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

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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).

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 as other states, because Georgia's CON process requires specialty hospitals 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. In contrast, 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, there is one issue that has received the most attention: whether to allow for the continued CON exemption for physician-owned, single specialty, free-standing ambulatory (outpatient) surgery centers (ASCs). Because hospitals claim physician-owned facilities, regardless of their structure, skim off profitable procedures from hospitals, hospitals would like to eliminate this exemption and thereby strengthen the CON process. Doctors would like to keep this exemption, and expand it to include general surgery ASCs, an ASC specialty currently not exempted for the CON process.

The author sees amending this exemption as a means to examine the effect on the health care industry of complete elimination of CON. This exemption, as currently

drafted, is inconsistent with the rationale behind CON because it requires physicians to *separately* create ambulatory surgical centers for each physician's group instead of allowing physicians to join forces with other groups and across specialties in order to build multi-service facilities. Amending this exemption to allow multi-group/specialty ASCs and to disallow single group ASCs would aggregate the resources needed to build these facilities and thereby reduce total overall expenditure. It would also enable the legislature to analyze the effect of physician-owned facilities on Georgia's health care industry. The author believes that, with amendments to the current staffing laws, hospitals could control any unfair competition by utilizing innovative delivery systems and, as a last resort, adverse credentialing strategies. This proposal would serve as a compromise to the current debate by addressing each party's concerns while enabling the legislature to address the health care cost crisis that has been the central focus of recent legislative sessions.

This paper will analyze Georgia's CON debate by initially discussing the history and status of CON nationally. Then, we will examine Georgia's CON process in detail and outline the debate over its repeal. The paper will also discuss how the advent of physician-owned "specialty" hospitals will affect the CON debate. Next, the author will propose amending Georgia's CON to allow for physician-owned multi-group/specialty ASCs. This legislation would address the concerns of the established hospitals while allowing the General Assembly to further examine the affect elimination of CON and the resulting competition will have on Georgia's health care market.

Lastly, the paper will discuss what actions existing hospitals should take to address the entry of the new ASCs, including proactively seeking ancillary joint ventures

with physician-owners to form their own ASCs. The paper also proposes amendments to provide incentives for physicians to include hospitals in the corporate structure of a new ASC. Finally, the paper will propose amending staffing laws to allow for the utilization of economic credentialing. This strategy will be discussed both nationally and in Georgia, and by outlining and addressing pitfalls hospitals may incur along the way.

I. Certificate of Need

In 1975, the National Health Planning and Resources Development Act was passed primarily in an attempt to slow increases in the cost of health care.[3] This act created funding for the administration of CON programs to participating states and conditioned the receipt of other funds to assist in construction and modernization of health facilities on state enactment of CON review legislation.[4] The purpose of a CON program is to insure the availability of adequate health services to meet the needs of a state's citizens, while safeguarding against the unnecessary duplication of services that perpetuate the costs of healthcare.[5] CON programs generally require the state agency in charge of the program to analyze the market need for the proposed facility or service prior to authorizing such a project.[6] If a favorable determination is made by the state agency, a certificate is issued allowing the project to move forward.[7]

a. The Unnecessary Expansion Phenomenon

The main rationale behind restricting entry into the healthcare industry stems from the belief that owners of health care facilities have a tendency to engage in

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[3] 42 U.S.C. 300k *et seq.* (repealed), 93 P.L. 641, 88 Stat. 2225 (1993).
[4] *Id*. at 300m-4, 300o.
[5] *Certificate of Need, Frequently Asked Questions*, Office of General Council, Georgia Department of Community Health (March 25, 2005), *available at* http://dch.georgia.gov/vgn/images/portal/cit_1210/2/53/32470863CON_FAQ_Review_Guide.pdf.
[6] *See, e.g.,* Ga. Code Ann. §31-6-40 (2006).
[7] *Id.*

unnecessary expansion of facilities and services.[8] This expansion is due in part to the unique characteristics of the industry's competition.[9] Unlike other industries, competition between hospitals arguably does not reduce costs, because hospitals do not compete for patients.[10] Instead, they compete for physicians, because physicians usually determine the hospital to which a patient is referred.[11]

Patients rely on physicians for this advice and advice as to what procedures are medically necessary because they lack the expertise of a physician.[12] The competition for physicians encourages hospitals to purchase high technology equipment and offer sophisticated services without sufficient regard to projected utilization rates.[13] This is compounded by the fact that many patients have insurance and, therefore, may only pay deductibles or co-pays, leaving them little incentive to question costs and react to cost increases.[14] Historically, health care facilities also were insufficiently deterred from incurring these expansion costs because of the "fee-for-service" payment system.[15]

i. The Fee-for-Service Payment System

These "fee-for-service" payment arrangements were the dominant method of payment in the health care industry at the time of the federal CON mandate.[16] After the patient received care, the health care provider billed the payor based on the provider's

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[8] Scott D. Makar, Antitrust Immunity Under Florida's Certificate Of Need Program, 19 Fla. St. U.L. Rev. 149, 155 (1991) (hereinafter Antitrust Immunity)
[9] *See* Statewide Health Coordinating Council v. General Hospitals of Humana, Inc., 660 S.W.2d 906, 908-909 (1983).
[10] *Id.* at 908.
[11] See i*d.* at 908-909.
[12] Mark E. Kaplan, An Economic Analysis of Florida's Hospital Certificate of Need Program and Recommendations for Change, 19 Fla. St. U.L. Rev 475, 481-482 (1991) (hereinafter Economic Analysis).
[13] *Id.*; See also, Antitrust Immunity, *supra*, note 8, at note 50.
[14] Economic Analysis, *supra*, note 12, at 481; Antitrust Immunity, *supra*, note 8, at note 50.
[15] Patrick John McGinley, Beyond Health Care Reform: Reconsidering Certificate of Need Laws in a "Managed Competition" System, 23 Fla. St. L. Rev. 141, 151 (1995) (hereinafter Beyond Reform).
[16] *Id.* at 150.

costs accrued in rendering the service.[17] These costs included amounts for overhead such as capital expenditures for new technology or facilities and operating costs in general.[18] These costs were ultimately passed to the public through higher insurance premiums or higher Medicare and Medicaid taxes.[19] Therefore, providers were able to expend capital resources for projects without bearing the brunt of the related costs.[20] However, this would soon change.

Four years after the enactment of the federal law mandating CON, Congress reversed its position and repealed its CON mandate.[21] Allegedly, CON failed to reduce the nation's aggregate healthcare costs and had detrimental effects on local communities.[22] However, many states, including Georgia, continued their regulation of health facilities through CON.[23] Some states have recently begun repealing state regulation amid debate over whether CON has had the desired effect.[24]

Opponents of CON programs claim that changes in healthcare payment systems since the inception of the CON process have eliminated the need for such programs.[25] Changes in the health care market have forced health care providers to contain costs and

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[17] *Id.* at 151.
[18] *Id.*
[19] *Id.*
[20] *Id.*
[21] *See* Health Planning and Resources Development Amendments of 1979, 96 P.L. 79, §§ 1-129, 93 Stat. 592 (1979) (codified at 42 U.S.C. §§ 300k *et seq.*); 99 P.L. 660, § 701, 100 Stat. 3743, 3799 (1986) (repealing the Health Planning and Resource Development Act of 1974).
[22] *See* Beyond Reform, *supra*, note 15, at 157.
[23] *See e.g.,* Ga Code Ann. § 31-6-1 *et seq.* (2006); Alaska Stat. § 18.07.021 *et seq.* (2006); 16 Del. C. § 9301 *et seq.* (2006) (repealed effective June 30, 2009); Ky. Rev. Stat. Ann. §§ 216B.010-.310 (Baldwin 2006); Miss. Code § 41-7-171 *et seq.* (2006); Mont. Code Ann. § 50-5-301 *et seq.* (2005).
[24] *See e.g.* 16 Del. C. § 9301 *et seq.* (2006) (repealed effective June 30, 2009); Ind. Code Ann. § 16-29-1-1 *et seq* (2006) (expired by its own terms on July 1, 1998, pursuant to IC 16-29-1-16, and repealed by P.L.1-2001, § 51, effective July 1, 2001); Kan. Stat. Ann. 65-4802 *et seq.* (2006) (repealed July 1, 1997); *See also* Beyond Reform, *supra*, note 15, at 159.
[25] *See e.g.,* Economic Analysis, *supra*, note 12, at 484.

become more efficient.[26] In particular, the "prospective payment system" (PPS) has replaced the retrospective "fee-for-service" payment system.[27]

ii. The Prospective Payment System

Under the PPS, the Centers for Medicare and Medicaid Services (CMS) has created more than 500 diagnosis related groups (DRGs) classified according to the clinical diagnosis of the patient and the procedures performed.[28] CMS assigns each DRG a "relative weight" that corresponds to the relative costliness of typical patients in that group.[29] CMS then sets a national base payment amount per discharge which represents what Medicare will pay for a case with a relative weight of 1.0.[30] These relative weights can be adjusted in exceptionally costly cases, or "outlier cases," where, because of particular patient circumstances, large losses would be incurred by the hospital.[31] The base payment amount is adjusted by factors, including primarily a wage index, that account for differences in input costs that hospitals have to pay in the local markets.[32] The DRG payment rate is thereafter determined by multiplying the adjusted national payment by the relative DRG weight.[33] This payment rate, however, can also be increased to reflect the hospital's status as a teaching hospital and/or a hospital's treatment of a disproportionate share of low-income patients.[34]

Therefore, unless the patient is considered an "outlier" case, the payor pays the same amount for the treatment of each patient/beneficiary in that particular DRG

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[26] *See id.* at 485-487.
[27] *See e.g.,* 42 C.F.R. § 412.1 *et seq.* (2006); Economic Analysis, *supra*, note 12, at 484.
[28] *See e.g.,* 42 C.F.R. § 412.60 (2006); MedPAC Report, *supra*, note 2, at 28.
[29] *Id.*
[30] *See* 42 C.F.R. § 412.64 (2006); MedPAC Report, *supra*, note 2, at 28.
[31] *See e.g.* 42 C.F.R. § 412.112 (2006); 42 C.F.R. § 412.80 (2006) MedPAC Report, *supra*, note 2, at 28.
[32] *See* 42 C.F.R. § 412.64; MedPAC Report, *supra*, note 2, at 28.
[33] *See* 42 C.F.R. § 412.64; MedPAC Report, *supra*, note 2, at 28.
[34] *See* 42 C.F.R. § 412.64; MedPAC Report, *supra*, note 2, at 28.

regardless of the amount of resources that the health care provider uses in rendering the service or treatment.[35] Outlier cases, however, typically only occur in high-cost DRGs because large losses are more likely to occur where average cost per case is high.[36] This technique of uniform prospective payment discourages unnecessary expansion of facilities and services by limiting the effect of those costs on the payment rate.[37] The PPS, therefore, encourages hospitals to operate more efficiently through utilization of only those resources that are medically necessary for the patient.[38]

iii. Managed Care

The entry of managed care also affects efficiency and cost in the health care market.[39] Not only do managed care companies generally utilize a similar prospective reimbursement system, they characteristically control costs by negotiating with providers; essentially, exchanging access to a patient referral source for discounted rates.[40] In addition, managed care companies have limited the unilateral decision-making authority of health care providers by requiring pre-approval of non-emergent care and/or post-care review to determine the medical necessity of the service provided.[41]

b. Other Concerns

Opponents of CON programs also contend that CON regulations are ineffective and possibly counterproductive in promoting efficient health care markets.[42] By restricting entry into the market, competition is reduced and therefore there is little incentive for the market participants to utilize innovative and/or more efficient

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[35] *See* 42 C.F.R. § 412.80; Economic Analysis, *supra*, note 12, at 484-485.
[36] MedPAC Report, *supra*, note 2, at 28.
[37] *See* Economic Analysis, *supra*, note 12, at 484-485.
[38] *See id.*
[39] *Id*. at 485-486.
[40] *Id*. at 486.
[41] *Id.*
[42] Antitrust Immunity, *supra*, note 8, at 155.

techniques.[43] Opponents also argue that the CON regulatory process protects incumbent firms from competition and innovation because new entrants have the burden of demonstrating that a current unfulfilled need exists in the marketplace.[44] Of course, this burden also lies with existing providers; however, they are in a much better position to fill that need because they already exist in the market and could provide these services with fewer capital expenditures. This burden reduces the possibility of entry by more efficient firms that would provide higher quality and/or lower cost services and, possibly, replace the less efficient firms.[45]

c. CON Studies

Proponents argue that CON has had the desired effect on containing healthcare costs since its inception in the mid-seventies.[46] A number of studies, however, have found that CON programs are ineffective in controlling costs and may adversely impact the quality of health care services.[47] In one comparison of health care prices and expenses, it was shown that such prices and expenses are actually higher in areas with CON regulations than they are in areas without CON.[48]

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[43] *Id.* at 155-156 (citing Federal Trade Commission and the Department of Justice, Improving Health care: A Dose of Competition (July 2004)).
[44] *Id.* at 156.
[45] *Id.* (citing FTC Letter from John M. Mendenhall to the Honorable John F. Pressman and the Honorable Donald W. Snyder (Mar. 30, 1988)).
[46] Citizens Research Council of Michigan, The Michigan Certificate of Need Program, 59 (February 2005) (hereinafter Michigan Study).
[47] Vickie Yates Brown, Barbara Reid Hartung, Andrew J. Murray & Tate M. Bombard, Kentucky Law Issue: Health Care Reform in Kentucky - Setting the Stage for the Twenty-First Century?, 27 N. Ky. L. Rev. 319, nt 48 (2000) (citing William Custer, Certificate of Need Regulations and the Health Care Delivery System, Research Report No. 97-1, Georgia State University Center for Risk Management & Insurance Research (1997); Kentucky Cabinet for Health Services, A Report on Certificate of Need in Kentucky, Health Policy & Analysis Research Branch, Certificate of Need Office (June 12, 1997)).
[48] Economic Analysis, *supra*, nore 12 at 478.

i. Washington Joint Legislative Audit and Review Committee

A report published by the State of Washington Joint Legislative Audit and Review Committee found that CON is not an effective mechanism for controlling overall per capita health care spending because of the numerous factors contributing to health care costs that are not covered by CON.[49] CON programs generally cover capital expenditures.[50] One of the primary areas CON regulates is bed supply.[51] This report noted that when bed supply was controlled, cost per bed tended to increase because often hospitals increased expenditures in other areas not covered by CON.[52]

Although supply of services has been restrained in some parts of the country, it is unclear whether supply of services is affected by CON repeal.[53] Not all states that have repealed CON have seen surges in supply of those services left unregulated.[54] However, there has been evidence of surges in some states after CON repeal: psychiatric and nursing homes in Utah; nursing homes and open heart surgery in Arizona; home health agencies in Tennessee; and hospitals, ambulatory surgery centers, dialysis, and pediatric services in Ohio.[55] Nonetheless, these surges tend to moderate over time.[56]

ii. FTC/DOJ Joint Report

The Federal Trade Commission (FTC) and the Department of Justice (DOJ) have jointly concluded that, on balance, CON programs are not successful in containing health

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[49] State of Washington Joint Legislative Audit and Review Committee, Effects of certificate of Need and its Possible Repeal, Report 99-1 (1999) (hereinafter Washington Audit).
[50] *See, e.g.,* Ga. Code Ann. §31-6-40.
[51] *See e.g. id.*
[52] Washington Audit, *supra,* note 49, at 10 (citing Conover, Christopher, and Frank A. Sloan, "Does Removing Certificate-of-Need Regulations Lead to a Surge in Health Care Spending?", *Journal of* Health Politics, Policy, and Law, Vol. 23, No. 3, June 1998).
[53] *Id.* at 11.
[54] *Id.*
[55] *Id.*
[56] *Id.*

care costs.[57] Their report stated that CON programs pose serious anti-competitive risks that usually outweigh their purported economic benefits.[58] Market incumbents can too easily forestall competitors from entering the market by filing objections to a CON application.[59] This report noted that CON programs increase prices by fostering anticompetitive barriers.[60]

However, a leading non-profit supporter of CON, the American Health Planning Association (AHPA), criticized the findings of the FTC/DOJ report as "doctrinaire posturing".[61] The AHPA claimed that the content of the report was expected, given the FTC's longstanding opposition to the CON programs.[62]

> Virtually all of the arguments against CON made by the FTC to State policymakers have been conjecture, based on theory and doctrine rather than acknowledged fact or demonstrated cause and effect. There are few reliable studies of the effects, if any, on the costs and charges for services subject to CON regulation. The results of studies that have been performed have been mixed. In the 1980s, when the FTC staff made representations about the negative effects of CON regulation on access, quality, innovation, and system efficiency, there were few, if any, studies or data that supported these arguments. They were assertions derived from an abiding faith in the effectiveness and unalloyed good of market forces.[63]

The AHPA instead cited as more reliable three studies that generally favor CON.[64] These three studies 'try to discern quality effects of CON regulation," instead of being regression or correlation studies that do not demonstrate or explain cause and effect.[65]

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[57] Federal Trade Commission and the Department of Justice, Improving Health care: A Dose of Competition (July 2004).
[58] *Id.* at 22.
[59] *Id.*
[60] *Id.*
[61] American Health Planning Association, The Federal Trade Commission & Certificate of Need Regulation, An AHPA Critique (January 2005) (hereinafter AHPA Critique*), available at* http://www.ahpanet.org/files/AHPAcritiqueFTC.pdf.
[62] AHPA Critique, *supra,* note 61.
[63] *Id.*
[64] *Id.*; Michigan Study, *supra* note 46, at 34.
[65] *Id.*; Michigan Study, *supra* note 46, at 34.

iii. The Automakers Report

The three studies cited by AHPA as being more reliable are those undertaken by the major American automobile manufacturers: Ford, Daimler-Chrysler, and General Motors.[66] These studies focused on a smaller group instead of the "macro-level" analyses that are more difficult to decipher because of states' differing benefit plans, varying demographics, and health status of the populations.[67] Each manufacturer conducted studies of relative costs per employee in states where they have significant employee presence.[68] Whereas other studies do not take into account state differences, these studies allegedly compared similar demographics in each state because of the manufacturers' tendency to employ similar employees regardless of the state.[69] Further, the employers' employee benefit plans did not differ from state to state.[70]

Each of these studies concluded similar results.[71] Indiana and Ohio, states that have eliminated CON programs, consistently had the highest relative costs.[72] Michigan, a state with a CON program, consistently had one of the lowest costs.[73]

d. Georgia's CON Commission

Now, it is Georgia's turn to examine the economic effect of eliminating its CON program. In 2006, the General Assembly created the State Commission on the Efficacy of the Certificate of Need Program (the Commission).[74] The Commission's purpose is to study and collect information and data relating to the effectiveness of the CON program

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[66] *Id*..; Michigan Study, *supra* note 46, at 34.
[67] Michigan Study, *supra* note 46, at 34.
[68] *Id* at 59.
[69] *Id.* at 34; The Daimler-Chrystler study was adjusted for age, gender and geography. *See id.* at Appendix G.
[70] *Id.* at Appendix G.
[71] *See id.*
[72] *Id.* at Appendix G.
[73] *Id.*
[74] Ga. Code Ann. § 31-6-90 *et seq.* (2006).

in Georgia.[75] It will study and evaluate the effectiveness and efficiency of Georgia's certificate of need program by reviewing the costs associated with the program, the benefits of continuing or discontinuing the program, the financial impact of continuing or discontinuing the program, and the impact on the quality, availability, and cost of health care if the program is continued or discontinued.[76] The Commission will also evaluate and consider the experiences and results in other states that use CON programs, and make recommendations for proposed legislation.[77] A final report will be issued, including proposed legislation, if any, to the Governor and the General Assembly on or before June 30, 2007.[78] However, some believed the issue would surface in the first three months of the year during the 2007 legislative session due to its priority among healthcare lobbyists' agendas.[79]

II. Georgia's Certificate of Need

In order to understand the proposed amendments outlined herein, one must first have an understanding of the general requirements of Georgia's CON. In terms of volume of items regulated Georgia's CON program ranks near the top.[80] The CON program in Georgia is administered by the Department of Community Health (DCH), and provides that only such new institutional health services or health care facilities as are found by DCH to be needed shall be offered in the state.[81] A "new institutional health service" means, for example, the construction of a new facility, any expenditure by a health

[75] Ga. Code Ann. § 31-6-91 (2006).
[76] Ga. Code Ann. § 31-6-94 (2006).
[77] *Id.*
[78] *Id.*
[79] 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.
[80] *See* Michigan Study, *supra,* note 46, at 4.
[81] Ga. Code Ann. § 31-6-40 .

facility over a certain monetary threshold set to allow for minor purchases, any increase in bed capacity, the purchase by a health facility of diagnostic or therapeutic equipment over a certain threshold, and new clinical health services like radiation therapy, ambulatory surgery, and cardiac catheterization.[82] Any person proposing to develop or offer a new institutional health service must submit an application to the department and obtain a certificate of need prior to beginning construction or implementation.[83]

a. General Review Criteria

In Georgia, the DCH will review the CON application by considering whether the population residing in the area served, or to be served, by the new institutional health service has a need for such services, and whether there are existing alternatives currently available, implemented, similarly utilized, or capable of providing a less costly alternative.[84] The costs and methods of a proposed construction project must be reasonable and adequate for quality health care, and the project must be adequately financed and financially feasible in the short and long term.[85] Further, the new health service must not unreasonably affect payors of health services.[86]

The relationship the proposed facility has with the existing health care delivery system in the service area will also be evaluated.[87] Also, the DCH will determine whether the proposed new institutional health service encourages more efficient utilization of the health care facility proposing such service.[88] It also is beneficial that the new service provide a substantial portion of its services to individuals not residing in its

[82] Ga. Code Ann. § 31-6-2 (2006).
[83] Ga. Code Ann. § 31-6-40.
[84] Ga. Code Ann. § 31-6-42 (2006).
[85] *Id.*
[86] *Id.*
[87] *Id.*
[88] *Id.*

defined service area or the adjacent service area.[89] The new health service should foster improvements or innovations in the financing or delivery of health services, promote health care quality assurance or cost effectiveness, or foster competition that is shown to result in lower patient costs without a loss of the quality of care.[90]

b. Provider-Specific Review Criteria

In addition to the general review criteria, the DCH will determine whether the proposed new institutional health service is reasonably consistent with the general goals and objectives of the relevant State Health Plan.[91] A State Health Plan is a comprehensive plan for each type of institutional health service adopted by the Health Strategies Council and approved by the Governor.[92] These plans identify and address health issues, recommending goals, objectives and system changes to achieve official state health policies.[93] There are currently eighteen component plans separated into three categories: acute care services, long-term care, and special services.[94] The plans outline criteria tailored to fit each type of service.[95] However, all plans have criteria analyzing need, quality, and access.[96]

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[89] *Id.*
[90] *Id.*
[91] Ga. Code Ann. § 31-6-42.
[92] *Id.*
[93] *See* Ga. Code Ann. § 31-6-2; Health Strategies Council, Georgia State Health Plan, Component Plan for Ambulatory Surgery Services, 3 (June 1998) (hereinafter ASC Component Plan), *available at* http://dch.georgia.gov/vgn/images/portal/cit_1210/16/37/32755444Ambulatory%20Surgery.pdf.
[94] Ga. Comp. R. & Regs. r. 111-2-2-.11 *et seq*. (2006).
[95] *See generally Id.*
[96] *See id.*; *See e.g.*, Ga. Comp. R. & Regs. r. 111-2-2-.11 *et seq*. (2006); However, see discussion regarding ASC "continuity" criteria, *infra*, at 93, as an example of a service specific criterion.

i. Need Analysis

All plans have some sort of need analysis designed to assess community need for the specific purpose sought in the application.[97] For example, the Short-Stay Hospital Component Plan states that an application shall be approved only if a new hospital located in a rural county will have at least 50 beds, and if located in a county other than a rural county, at least 100 beds.[98] In addition, the total target service area population must be at least 50,000 persons.[99] Further, the need for a new hospital is determined through application of a demand-based forecasting model, based in part on calculating the use rate of the current hospital services, projections for use of hospital services five years from the application date, the amount of use by out-of-state patients, the optimal occupancy rate, and the total population of the counties within ten miles of the proposed facility.[100]

ii. Quality Analysis

The applicant must also meet a quality test.[101] Generally an applicant must prove that the service facility has some sort of credentialing process, qualified support personnel, care management and quality assurance policies and plans, utilization review, and licensing and accreditation from appropriate accrediting bodies such as the Joint Commission for the Accreditation of Healthcare Organizations (JCAHO).[102]

iii. Access Analysis

Also involved is a determination of the applicant's accessibility by indigent elements of the state's population.[103] Criteria may include whether the service facility

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[97] *See id.*
[98] Ga. Comp. R. & Regs. r. 111-2-2-.20(b)(3) (2006).
[99] *Id.*
[100] *Id.*
[101] *Id.*
[102] *See generally* Ga. Comp. R. & Regs. r. 111-2-2-.11 *et seq.*
[103] *See generally* Ga. Comp. R. & Regs. r. 111-2-2-.11 *et seq.*

has comparable charges to other similar service facilities in the area and administrative policies and directives related to providing services on a non-discriminatory basis, provides information to patients regarding arrangements for satisfying charges, and what percentage of the adjusted gross revenue is or will be uncompensated care.[104] For example, the review board may give favorable consideration to a hospital that historically has provided a higher annual percentage of un-reimbursed care to indigent and charity patients and a higher annual percentage of services to Medicare, Medicaid and PeachCare patients.[105]

c. Exemptions

Georgia law provides for exemptions from the CON process for certain projects.[106] Exempted projects include repairs to a facility or acquisitions by the facility below the annually adjusted CON review threshold of $823,934, the replacement of existing therapeutic or diagnostic equipment that received prior CON authorization, projects that bring facilities into compliance with licensing requirements, life safety codes or standards of the Joint Commission on Accreditation of Healthcare Organizations, and certain project cost overruns.[107] Further, a hospital that maintains an occupancy rate greater than 85 percent for the preceding 12-month period may increase its capacity by 10 beds or 10 percent of its existing inventory, whichever is less, every two years without a CON unless the cost associated with the increase exceeds an annually adjusted capital threshold of $1,483,083.[108] Lastly, an ambulatory surgery facility does not need a CON

[104] *See* Ga. Comp. R. & Regs. r. 111-2-2-.40.
[105] Ga. Comp. R. & Regs. r. 111-2-2-.20 (e); The PeachCare for Kids Program provides health care benefits for children in families with income below 235 percent of the federal poverty level. Ga. Code Ann. § 49-5-273 (2006).
[106] Ga. Code Ann. § 31-6-47 (2006).
[107] *Id.*
[108] *Id.*

if that facility is physician-owned, office-based, and single-specialty.[109] Further, the establishment and development of the facility cannot exceed the limited-purpose physician-owned ambulatory surgery centers threshold, currently $1,610,823.[110]

Any entity that falls under an exception outlined above need not apply for a certificate of need.[111] However, a "Letter of Non-reviewability" is required.[112] A letter of non-reviewability is a procedure adopted by the Health Planning Agency whereby an entity obtains an exemption from the certificate of need application process.[113] A person requesting a letter of non-reviewability shall make such a request in writing and shall specify in detail all relevant facts which relate to the proposed action, including a statement citing the statutory provision or other authority under which the letter of non-reviewability is to be granted by the Department.[114]

d. The Debate

The formation of the Commission on Certificate of Need Efficacy signals the beginning of a legislative struggle that puts against each other two foes that normally support the same agenda. Physicians support the deregulation of the CON process because they claim it is anticompetitive, leading to lower quality and higher costs.[115] As explained below, physicians stand to gain financially from the elimination of CON in Georgia by being able to freely enter into competition with existing hospitals.[116] Existing hospitals believe that elimination of the CON program will lead to hospital closure and

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[109] *Id.*
[110] *Id.*
[111] Ga. Code Ann. § 31-6-40 (c)(5).
[112] Ga. Comp.R. & Reg. r. 111-2-2-.10 (2006).
[113] Ga. Code Ann. § 31-6-40(c)(5).
[114] Ga. Comp.R. & Reg. r. 111-2-2-.10.
[115] *See* Gold Dome Report, Certificate of Need Commission Update (August 8, 2005), *available at* www.gcn.org.
[116] *See* The Specialty Hospital Issue, *infra*.

decreased access to healthcare for the citizens of Georgia.[117] Hospitals claim that approximately sixty percent of Georgia hospitals are already losing money providing patient care, and the entry of new competitors will exacerbate such pressure.[118] Hospitals could be forced to cut back in areas of indigent care, including outpatient clinics and trauma and emergency services in order to maintain their financial viability.[119]

III. The Specialty Hospital Issue

Prior to making any judgment regarding the CON program, the Commission should consider how innovative delivery systems being utilized throughout the nation in non-CON states will affect Georgia's established hospitals. Physician-owned specialty hospitals generally are located in states that do not require state approval prior to building or improving upon a healthcare facility.[120] Eighty-three percent of all specialty hospitals, fifty-five percent of general hospitals and fifty percent of the United States population are located in states without CON requirements.[121] The entry of these specialty hospitals into Georgia's healthcare market could cripple some hospitals by taking from the existing hospitals the most profitable procedures.[122] This occurrence should be the primary concern for the Commission in deciding whether to eliminate or amend Georgia's CON program.

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[117] *See* Preserving CON, *supra,* note 79 at 13.
[118] *Id.*
[119] *Id.*
[120] U.S. Gen. Acct. Office, Specialty Hospitals: Geographic Location, Services Provided, and Financial Performance, GAO Report, GAO-04-167, 15 (October 2003) (hereinafter GAO Geographic Location); U.S. Dept. of Health and Human Services, Final Report to the Congress and Strategic and Implementing Plan Required Under Section 5006 of the Deficit Reduction Act of 2005, 6 (August 2006) (hereinafter HHS Final Report).
[121] GAO Geographic Location, *Supra*, note 120, at 15.
[122] William T. Richardson, A Call to Action on Certificate of Need, GHA Today, 2 (May/June 2006).

The federal government is currently addressing what action, if any, it should take to combat the formation of specialty hospitals.[123] Specialty hospitals are defined as hospitals that are exclusively or primarily engaged in the care or treatment of cardiac patients, patients with an orthopedic condition, or patients receiving surgical care.[124] Advocates of specialty hospitals claim that specializing in certain procedures increases efficiency and quality.[125] The hospitals, it is argued, also may increase patient comfort and convenience by tailoring their facilities and resources to best fit the services they are providing.[126] Focused resources and an improved work environment can also enable physicians to treat more patients.[127] Physicians desire to admit patients, perform the procedures, and have patients recover with minimal disruption.[128] Control over the hospital's operations, they believe, makes this possible in ways community hospitals cannot match.[129] Physicians practicing in specialty hospitals also have more control over scheduling and purchasing.[130] These factors together create an environment where physicians and staff can render higher-quality health services.[131] Proponents also claim that these innovations in care force improvements in non-specialty hospitals in order to keep pace.[132]

a. Moratorium

Due in part to concerns regarding specialty hospitals and their effect on general community hospitals, in 2003 Congress imposed an 18-month moratorium on physician-

[123] *See* HHS Final Report, *supra*, note 120 at 78.
[124] *Id.*
[125] Steinwald Letter, *supra*, note 136 at 1.
[126] *Id*.
[127] *Id*.
[128] *See* MedPAC Report, *supra*, note 2, at 7.
[129] *Id.*
[130] Steinwald Letter, *supra*, note 136 at 1.
[131] *Id*.
[132] HHS Final Report, *supra*, note 120 at 1.

owner referrals to specialty hospitals, except for those specialty hospitals already under development.[133] This moratorium, passed as part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), was in effect from December 8, 2003 until June 7, 2005.[134] The MMA, also mandated that the Department of Health and Human Services (HHS) and the Medicare Payment Advisory Commission (MedPAC) study concerns regarding specialty hospitals.[135] These concerns are outlined below.

b. Concerns Regarding Specialty Hospitals

Opponents of specialty hospitals have numerous complaints about the formation and operation of specialty hospitals. The concerns most often cited are specialty hospitals' abuse of the Stark Law whole hospital exception, conflicts of interests that promote over-utilization, specialty hospitals' tendency to cherry-pick profitable patients, and specialty hospitals' failures to provide emergency departments.[136]

i. Concern #1: Abusing the "Whole Hospital" Exception

Physicians have begun creating their own hospitals, capitalizing on the "whole hospital" exception to the Stark self-referral law.[137] The Stark law prohibits physicians from making referrals for designated health services to entities when the physician has a financial relationship with the entity to which the patient is being referred.[138] However, there is an exception for services provided by a hospital if the physician has an ownership

[133] Medicare Prescription Drug, Improvement, and Modernization Act of 2003, § 507, 108 P.L. 173, 117 Stat. 2066 (2004) (amending 42 U.S.C. § 1395 nn).
[134] *See id.* at § 507(a)(1).
[135] *See id.* at § 507 (c).
[136] *See e.g.* HHS Final Report, *supra*, note 120, at 78; MedPAC Report, supra, note 2, at 20-23; Letter from A. Bruce Steinwald, Director, Health Care Economic and Payment Issues, United States General Accounting Office, to Bill Thomas, Chairman, Committee on Ways and Means, House of Representatives, and jerry Kleczka, House of Representatives, GAO-03-683R Specialty Hospitals (April 18, 2003) (hereinafter Steinwald Letter); Kelly J. Devers et al., Ctr. for Studying Health Sys. Change, Specialty Hospitals: Focused Factories or Cream Skimmers, 1-3 (2003) *available at* http://www.hschange.com/CONTENT/552/552.pdf (hereinafter Devers).
[137] *See* HHS Final Report, *supra*, note 120 at 78.
[138] 42 U.S.C. § 1395nn (2006).

interest in the hospital.[139] This exception is referred to as the "whole hospital" exception because it applies to ownership interest in the hospital itself and not merely in a subdivision of the hospital, such as a department.[140]

Opponents of specialty hospitals contend that allowing physician ownership of specialty hospitals is contrary to the spirit of the whole hospital exception because ownership in a specialty hospital is more akin to ownership of a department of a full-service hospital.[141] This concern is more targeted toward orthopedic and surgical hospitals than cardiac hospitals, because the former generally focus on outpatient care as opposed to inpatient care.[142] A hospital is defined as a facility primarily engaged in inpatient care.[143] Specialty hospitals satisfy the definition of a hospital by claiming to focus primarily on inpatients.[144] However, because orthopedic and surgical specialty hospitals normally do not require overnight admissions, they more closely resemble ambulatory surgical centers (ASCs).[145]

ASCs are defined as public or private facilities, not part of a hospital, which provide surgical treatment performed under general or regional anesthesia in an operating room environment to patients not requiring hospitalization.[146] ASCs differ from specialty hospitals and hospitals in general in that they concentrate on only patients who are admitted for outpatient surgery and do not normally require stays that are overnight or

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[139] 42 U.S.C. § 1395nn (d)(3).
[140] *Id.*
[141] *Id.*
[142] *See* HHS Final Report, *supra*, note 120 , at 64.
[143] 42 U.S.C. § 1395x (e).
[144] *See* Social Security Act of 1965, Section 1861(e).
[145] HHS Final Report, *supra*, note 120 at 64.
[146] Ga. Comp. R. & Regs. r. 111-2-2-.40 (2006).

exceed twenty-four hours.[147] Further, ASCs do not provide accommodations for treatment of patients for periods of twenty-four hours or longer.[148]

By acting as a hospital instead of an ASC, physicians avoid violating the self-referral statute while capitalizing on a higher reimbursement rate.[149] Medicare does not pay a facility fee for patients who require an overnight stay if their procedure is performed in an ASC.[150] By converting to a hospital from an ASC, physician-owners can position themselves to receive this additional facility fee.[151]

ii. Concern #2: Conflict Of Interest and Over-utilization

Opponents also contend that allowing physician ownership in specialty hospitals creates an impermissible conflict of interest between the physician's duty to render care and the physician's financial interest.[152] This conflict, opponents claim, leads to increased utilization of the services offered by the specialty hospital.[153] For example, a patient with a moderate heart condition that could normally be treated with less invasive and less profitable angioplasty may be referred to a specialty heart hospital for a more invasive and more profitable coronary artery bypass graft surgery because the physician has a financial incentive to do so.

MedPAC addressed this concern in its report to congress in 2005.[154] This report showed that the increases in cardiac surgery rates associated with the opening of

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[147] *See* Ga. Comp. R. & Regs. r. 111-2-2-.40.
[148] *Id.*
[149] *See* 42 U.S.C. § 1395nn (d)(3); MedPAC Report, *supra,* note 2, at 5; *compare* 42 C.F.R. § 419.32 (2006), *with* 42 C.F.R. § 416.120 (2006); Changes to the Hospital Outpatient Prospective Payment System and Calendar Year 2006 Payment Rates, 70 Fed. Reg. 68,516, Addendum A (November 10, 2005).
[150] 42 C.F.R. § 416.65 (2006).
[151] *See* HHS Final Report, *supra*, note 120 at 64.
[152] *See* MedPAC Report, supra, note 2, at 20-23; Physician-*owned Specialty Hospitals: Hearing before the S. Comm. on Finance,* 109th Cong., 4 (2005) (statement of Glenn M Hackbarth, J.D., Chairman, Medicare Payment Advisory Commission) (hereinafter Hackbarth Testimony).
[153] *Id.*
[154] MedPac Report, *supra*, note 2, at 21-23.

physician-owned specialty heart hospitals were small enough to be statistically insignificant.[155] From 1996 to 2002, cardiac surgeries as a whole rose by 5.5 surgeries per 1,000 Medicare beneficiaries in markets with specialty heart hospitals and by only 4.4 surgeries per 1,000 Medicare beneficiaries in markets without specialty heart hospitals.[156] MedPAC concluded that the specialty heart hospitals were merely capturing a portion of the market share of these procedures from community hospitals.[157] However, the report also noted that the small changes in utilization were always in the direction that would be predicted by looking at financial incentives.[158]

iii. Concern #3: Cherrypicking

Opponents of specialty hospitals also argue that these facilities and their physician owners skim off the most profitable procedures, patients, and payors.[159] Physicians generally have a choice, subject to approval by the patient, as to which facility to refer a patient.[160] Having a financial interest in the specialty hospital, it is argued, influences these physicians to refer the more profitable patients to that hospital.[161] Hospitals are typically paid the same fixed, lump-sum amount for patients with the same diagnosis regardless of the severity of their illness.[162] The more profitable patients tend to be the patients that are less sick, relative to other patients, and therefore require fewer

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[155] *Id.* at 22.
[156] *Id.* at 22-23.
[157] *Id.* at 23.
[158] *Id.*
[159] Letter from A. Bruce Steinwald, Director, Health Care Economic and Payment Issues, United States General Accounting Office, to Bill Thomas, Chairman, Committee on Ways and Means, House of Representatives, and jerry Kleczka, House of Representatives, GAO-03-683R Specialty Hospitals (April 18, 2003) (hereinafter Steinwald Letter).
[160] *See Statewide Health*, *supra*, note 9, at 908-909.
[161] Steinwald Letter, *supra,* note 136 at 1-2.
[162] *Id*. at 2.

services.[163] Under the prospective payment system (PPS), discussed *supra*, hospitals are paid the same amount for each patient in a diagnosis related group (DRG) regardless of the severity of the patient's illness relative to other patients within the same DRG.[164] Specialty hospitals capitalize on this disparity by focusing on less sick patients, thus leaving the sicker, less profitable patients to be treated by the competing community hospitals.[165]

Profitability can be influenced by the risk posed by the patient due to the severity of illness.[166] Certain physical attributes, like age or weight, tend to make patients more of a risk for complications.[167] Complications require the extension of more resources to treat the patient; however, under the PPS, no correlating additional reimbursement is provided to the hospital.

Further, specialty hospitals focus their services on or away from certain payors.[168] Medicaid, for instance, reimburses providers at lower rates than other payors.[169] Therefore, by failing to refer Medicaid patients to the specialty hospital, the physician will make his investment more profitable and the community hospital less profitable. MedPAc found that specialty heart hospitals primarily treated Medicare patients, (which

[163] HHS Final Report, *supra*, note 120 at 78.
[164] *Id.*; As mentioned above, note 120 and corresponding text, orthopedic and surgical hospitals typically focus on outpatient surgery, therefore, the idea that specialty hospitals take advantage of the DRG payment system generally pertains to cardiac hospitals that typically treat inpatients. *See* HHS Final Report, *supra*, note 120 at 64, note 96.
[165] *Id*.
[166] *See* GAO Geographic Location, *supra*, note 120, at 4.
[167] *See id.* at 1.
[168] Hackbarth Testimony, *supra*, note 152, at 5.
[169] David N. Heard, Jr., The Specialty Hospital Debate: The Difficulty of Promoting Fair Competition Without Stifling Efficiency, 6 Hou. J. Health L. & Pol'y 215, 221 (2005) (hereinafter Specialty Hospital Debate).

has relatively generous cardiac reimbursement) while orthopedic and surgical hospitals treated privately insured patients.[170]

iv. Concern #4: Emergency Care

Opponents of specialty hospitals are also concerned about specialty hospitals' failures to provide emergency services.[171] Specialty hospitals typically do not have emergency departments (EDs).[172] Ninety-two percent of all general hospitals have EDs compared to forty-five percent of specialty hospitals.[173] The percentage of specialty hospitals with EDs, however, varies depending on the specialty service provided.[174] For example, seventy- two percent of cardiac hospitals have EDs, compared to only thirty-three percent of orthopedic hospitals.[175] Only sixty-three percent of these specialty hospitals reported having 24-hour emergency physician staffing.[176] For orthopedic and surgical specialty hospitals, this number dropped below one-third.[177]

Specialty hospitals usually do not provide emergency care because they generally are not required to provide any "community benefit" due to their status as for-profit entities.[178] For-profit entities are not required to provide a community benefit.[179] Approximately ninety percent of specialty hospitals are classified as for-profit.[180]

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[170] Hackbarth Testimony, *supra*, note 152, at 5.
[171] Kelly J. Devers et al., Ctr. for Studying Health Sys. Change, Specialty Hospitals: Focused Factories or Cream Skimmers, 1-3 (2003) (http://www.hschange.com/CONTENT/552/552.pdf) (last visited November 13, 2006) (hereinafter Devers).
[172] *See id.*
[173] *Id.*
[174] *Id.*
[175] *Id.*
[176] *Id.* at 19.
[177] *Id.* at 20.
[178] *See Study of Physician-Owned Specialty Hospitals Required in Section 507(c)(2) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003*, Centers for Medicare & Medicaid Services, 55 (2005), *available at* http://www.cms.hhs.gov/MLNProducts/Downloads/RTC-StudyofPhysOwnedSpecHosp.pdf (hereinafter HHS MMA Report).
[179] *See id.*; HHS MMA Report, *supra*, note 178, at 56.
[180] *Id.*

Approximately eighty percent of all non-specialty hospitals are non-profit tax-exempt entities.[181] Non-profit tax-exempt hospitals are required to provide a certain level of "community benefit" in order to maintain their tax exemption.[182] The provision of emergency care to the community is one type of community benefit.[183] Some specialty hospitals, however, have charity care policies in place that look similar to those at community hospitals.[184] Specialty hospitals' failure to provide emergency care raises concerns relating to access to care as well as quality of care.[185]

1. Access to Care

Opponents are concerned that, by taking away community hospitals' ability to cross-subsidize less profitable services, community hospitals will not be able to provide as much community or charity care, which affects access to care.[186] Cross-subsidization is a strategy utilized by hospitals to offset losses from below-cost or uncompensated care with revenues from more profitable procedures in other areas of the hospital's operations.[187] Hospitals with EDs are more likely to treat Medicaid patients because of the program's coverage of pregnant mothers.[188] Also, because of the Emergency Medical Treatment and Active Labor Act (EMTALA), discussed in detail below, most hospitals with EDs are required to provide treatment to uninsured patients.[189] Because of Medicaid's lower reimbursement rates, and the lack of reimbursement in the case of some

[181] GAO Geographic Location, *supra*, note 120, at 8.
[182] *See* I.R.C. § 501 (c)(3) (2000); Rev. Rul. 69-545, 1969-2 C.B. 117.
[183] Rev. Rul. 69-545, 1969-2 C.B. 117.
[184] HHS MMA Report, *supra*, note 178, at 56.
[185] *Id.*
[186] *See* GAO Geographic Location, *supra*, note 120, at 17.
[187] *See* Devers, *supra*, note 136, at 2.
[188] *See* HHS Final Report, *supra*, note 120, at vi.
[189] 42 U.S.C. § 1395dd (2006).

uninsured patients, emergency care leads to reduced surplus.[190] Therefore, to ensure their ability to continue providing emergency care, community hospitals need to have the ability to cross-subsidize these unprofitable procedures with more profitable procedures.[191]

If specialty hospitals skim the most profitable cases, this reduces the general hospital's ability to cross-subsidize, and therefore decreases the amount of charity or emergency care the hospital is able to provide.[192] For example, cardiology services, a quite profitable hospital service, can account for 35% of community hospital revenues.[193] The formation of a cardiology specialty hospital in the market will reduce the amount of these procedures performed at the community hospital, and therefore reduce the amount of the hospital's total revenue.[194] This reduction in revenue could lead the hospital to cut community outreach programs, burn units, psychiatric units, outpatient clinics, and even emergency services.[195]

Community hospitals also feel that specialty hospitals without an ED have an unfair advantage in regards to civil liability.[196] Not only do they reduce the prospect of malpractice claims, but they may also not be subjected to civil liability under EMTALA.[197] Hospitals that receive Medicare reimbursement and that have an ED must, without regard to the individual's ability to pay, provide an appropriate medical screening and, if an emergency exists, render stabilizing treatment to all individuals who present to

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[190] *See* Devers, *supra*, note 136, at 3.
[191] *Id.* at 2.
[192] Preserving CON, *supra*, note 79, at 13.
[193] Devers, *supra*, note 136, at 2.
[194] *Id.*; Preserving CON, *supra*, note 79, at.
[195] Devers, *supra*, note 136, at 2; Preserving CON, *supra*, note 79, at 13.
[196] *See* Specialty Hospital Debate, *supra*, note 169, at 220 (citing Paula Spurway, Blue Cross & Blue Shield Ass'n, Straight Talk News Letter: Hospital Services and the Rising Cost of Health Care (Sept. 2003), http://www.fepblue. org/toyourhealth/tyhhchospitalcosts.hmtl.
[197] 42 U.S.C. § 1395dd;

the ED requesting treatment.[198] If the ED does not have the capacity to stabilize the patient, it must execute what is referred to as an "appropriate transfer."[199] An appropriate transfer is one in which the transferring hospital provides treatment within its capacity, the receiving facility has available space and personnel for the treatment of the patient and has agreed to accept the transfer, all medical records are sent to the receiving hospital, and it is effected through qualified personnel and transportation equipment.[200] EMTALA also outlines the obligation of hospitals to receive appropriate transfers from other hospitals.[201] Typically, when an individual presents to an ED with a condition that cannot be stabilized at the ED and requires specialized treatment, the hospital will transfer the patient to a facility with specialized capabilities to render the stabilizing treatment.[202] However, it was unclear under regulations whether a receiving hospital that does not have an ED must accept the transfer.[203] If the receiving hospital did not have an ED, then arguably EMTALA did not apply to the hospital and therefore the hospital may not be required to accept the transfer.[204]

Opponents argue that avoiding these liability concerns and not having to provide charity care creates an unfair advantage for specialty hospitals. However, as for-profit entities, specialty hospitals pay taxes that do not apply to non-profit tax-exempt hospitals, which more than makes up for the amount expended on charity care.[205] A report published by the Centers for Medicare & Medicaid Services (CMS) determined that,

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[198] *Id.*
[199] *Id.*
[200] *Id.*
[201] *Id.*; 42 C.F.R. § 489.24 (f) (2006).
[202] Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates, 71 Fed. Reg. 47870, 48143 (August 18, 2006)
[203] *Id.*; 42 C.F.R. § 489.24(f) (2005).
[204] *Id.*
[205] *Compare* I.R.C. § 11 (2006), *with* I.R.C. § 501 (c)(3).

overall, the proportion of net revenue that specialty hospitals devote to both uncompensated care and taxes significantly exceeds the proportion of net revenues that competitor hospitals devote to uncompensated care.[206]

2. Quality of care

Specialty hospitals' failure to provide emergency care also creates quality concerns.[207] Specialty hospitals may put patients at risk by having limited capacity within their emergency departments or by the complete absence of emergency services.[208] Some specialty hospitals only have the capabilities to handle emergencies related to the specialty service they provide.[209] Specialty hospitals may not have appropriate arrangements in place to timely address emergency transfers.[210] Further, the ED may be inadequately staffed and incapable of addressing emergency medical conditions other than those in which the hospital specializes.[211]

c. Additional Findings

Opponents' claims have been partially confirmed through federal government studies.[212] An April 2003 General Accounting Office (GAO) study concluded that patients at specialty hospitals tended to be less sick than patients with the same diagnosis at general hospitals.[213] It found that 21 out of 25 specialty hospitals studied treated a lower percentage of patients who were severely ill than did general hospitals.[214]

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[206] *See* HHS MMA Report, *supra*, note 178, at 59.
[207] Devers, *supra*, note 136, at 2.
[208] *See id.*
[209] *Id.*
[210] *Id.*
[211] *Id.*
[212] *See, e.g.,* HHS Final Report, *supra*, note 120; U.S. Gen. Acct. Office, Specialty Hospitals: Information on Market Share, Physician Ownership, and patients Served, GAO Report, GAO-03-683R (April 2003) (hereinafter GAO Market Share); GAO Geographic Location, *supra*, note 212.
[213] *See* GAO Market Share, *supra*, note 212 at 4.
[214] *Id.*

Two years later, MedPAC confirmed this finding and found that physician-owned specialty hospitals' patients have shorter lengths of stay, which should lead to lower costs.[215] These hospitals tend to have lower shares of Medicaid patients than competitor hospitals as well, although this maybe explained by general hospitals' provision of obstetric services and the existence of EDs.[216] However, specialty hospitals had a lower percentage of Medicaid patients than did other hospitals with similar specialization that were not physician-owned.[217]

MedPAC concluded that the financial impact of specialty hospitals on competitor hospitals has been limited thus far, but specialty hospitals had a much larger margin for all payors relative to community hospitals.[218] However, although the opening of specialty heart hospitals was associated with slower growth in Medicare inpatient revenue at community hospitals, on average, community hospitals competing with physician-owned heart hospitals did not experience unusual declines in their all-payor profit margin.[219] The limited impact could be due to the community hospitals' changes in operations.[220] Community hospitals have reported various strategies to compensate for the loss of revenue: staff cuts, aggressive price strategies to raise revenue from private payors, and expansion into more profitable areas such as imaging, rehabilitation, pain management, and neurosurgery.[221]

The above concerns were not lessened by the reports issued by HHS and MedPAC. Upon the expiration of the specialty hospital moratorium, CMS instituted a

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[215] *See* MedPac Report, *supra*, note 2 at 16, 25, 32.
[216] *Id*. at 17-19.
[217] *Id*. at 18, table 6.
[218] *Id*. at 22-24.
[219] *Id.*
[220] *Id.* at 24.
[221] *Id.*

suspension of enrollment into the Medicare program for specialty hospitals, effectively extending the moratorium.[222] This suspension was extended by CMS and then continued by Congress under the Deficit Reduction Act of 2005.[223] It expired on August 8, 2006.[224]

Accordingly, physician-investors are now able to freely form specialty hospitals.[225] An elimination of Georgia's CON program would enable these specialty hospitals to invade the state at the same rate as in other non-CON states. HHS estimated that, upon the expiration of the moratorium, thirty-seven new specialty hospitals would be created within a year or two, all in states without CON.[226] Therefore, it is imperative that Georgia's CON Commission take into consideration the effect HHS proposed changes will have on specialty hospitals and the incentives physicians have to form them.

d. HHS Solutions to Specialty Hospital Concerns

In an effort to address specialty hospital opponents' concerns, the Deficit Reduction Act of 2005 mandated that HHS address certain issues relating to physician investment and the provision of care by physician-owned specialty hospitals.[227] HHS was mandated to develop a strategic and implementing plan related to those issues.[228] Not included among the issues specified in the mandate is the question of whether the "whole hospital" exception should be repealed or modified with respect to specialty hospitals.[229] Therefore, at least for the time being, physician ownership of specialty

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[223] Deficit Reduction Act of 2005, § 5006 (c) 109 P.L. 171, 120 Stat. 4 (2006).
[224] *See id.*
[225] *See id.*
[226] HHS Final Report, *supra*, note 120, at 8.
[227] Deficit Reduction Act of 2005, § 5006 (c) 109 P.L. 171, 120 Stat. 4 (2006).
[228] *Id.* at § 5006 (a)
[229] HHS Final Report, *supra*, note 120 at 78; *See generally* Deficit Reduction Act of 2005, § 5006 (c) 109 P.L. 171, 120 Stat. 4 (2006).

hospitals will be permitted.[230] Thus, HHS focused on other solutions to the problems surrounding the specialty hospitals.[231]

The resulting Final Report from HHS focused on a five-pronged approach to dealing with specialty hospitals: (1) continue making improvements to the CMS payment systems, (2) align physician and hospital incentives, (3) issue guidance on patient safety measures, (4) promote transparency of investment, and (5) enforce current laws.[232] This plan identifies administrative measures that CMS has undertaken or intends to initiate.[233]

i. Solution Prong #1: Reform the CMS Payment System

The first and most comprehensive prong addresses four ways to change the CMS payment systems.[234] These changes were recommended by CMS and have been, or will be, implemented soon.[235] The changes include: (1) reforming the payment rates for inpatient hospital services through DRG refinements, (2) reforming the payment rates for ambulatory surgical centers, (3) more closely scrutinizing whether specialty hospitals meet the definition of a hospital in section 1861(e) of the Act, and (4) reviewing criteria for enrolling new specialty hospitals into the Medicare program.[236]

1. Payment System Reform #1: DRG Refinements

The first change entails reforming the payment rates for inpatient hospital services through DRG refinements.[237] HHS believes that making the DRG payment system more accurate is the most effective way to combat the perceived unfair competition by

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[230] HHS Final Report, *supra*, note 120 at 78.
[231] *Id.*
[232] *See id.* at 63.
[233] *See id.*
[234] *Id.*
[235] 71 Fed. Reg. 47870, 48143.
[236] 71 Fed. Reg. 47870, 48143; HHS Final Report, *supra*, note 120 at 13-14, 63-76; MedPAC Report, *supra*, note 2, at 35-44.
[237] HHS Final Report, *supra*, note 120 at 14; MedPAC Report, *supra*, note 2, at 35-44.

specialty hospitals.[238] Leveling the profitability of certain DRGs would eliminate any incentive physicians would have to cherry-pick patients.[239] Therefore, the inpatient PPS final rule will be altered for 2007.[240] Changes include altering existing DRGs to more fully capture differences in severity of illness and changing the basis of the DRG relative weights from estimated charges to hospital-specific costs.[241]

CMS has proposed that the PPS be refined to more fully capture differences in severity of illness.[242] It is possible for some DRGs to have a high variation in resource costs depending on the severity of the illness in the patient.[243] Recognizing these variances, and adjusting the DRGs accordingly, reduces incentives for hospitals to select patients meeting certain profitable criteria within these DRGs.[244] Therefore, CMS is creating 20 new DRGs and modifying 32 others across 13 different clinical areas involving 1,666,476 cases that would improve the DRG system's recognition of severity of illness for FY 2007.[245] Twelve of the new DRGs are medical and 8 are surgical.[246]

In addition, CMS will begin implementing a three year transition to base DRG weights on hospital-specific estimated costs of providing care instead of on the standardized charges billed by hospitals.[247] The DRG relative weights were previously based on a national average of hospital's charges billed to Medicare for patients in each

[238] HHS Final Report, *supra*, note 120 at 63.
[239] *Id.* at 63-63.
[240] *Id.* at 64.
[241] HHS Final Report, *supra*, note 120 at 14; MedPAC Report, *supra*, note 2, at 35-44.
[242] HHS Final Report, *supra*, note 120 at 14; MedPAC Report, *supra*, note 2, at 35-44.
[243] HHS Final Report, *supra*, note 120 at 14; MedPAC Report, *supra*, note 2, at 35-44.
[244] *See* HHS Final Report, *supra*, note 120 at 14-15; MedPAC Report, *supra*, note 2 at 35-44.
[245] 71 Fed. Reg. 47870, 47923.
[246] 71 Fed. Reg. 47870, 47924.
[247] 71 Fed. Reg. 47870, 47882-47883; HHS Final Report, *supra*, note 120 at 15; MedPAC Report, *supra*, note 2, at 35-44.

DRG.[248] These charges might over- or under-estimate the expected cost depending on what pricing strategies hospitals use to price there services.[249] Therefore, the FY 2007 PPS rule will change the relative weight calculation to use hospital-specific relative weights, instead of the standardized structure that is subject to be influenced by a single hospital that provides a higher proportion of total nationwide discharges in a particular DRG.[250] The proposed changes to the relative weights could result in significant changes to hospital payments.[251]

2. Payment System Reform #2: Ambulatory Surgical Centers

CMS's second recommendation regarding how to address the specialty hospital problem is to reform the payment rates for ASCs.[252] Reimbursement differences between ASCs and hospital outpatient services provide an incentive for physicians to open surgical and orthopedic specialty hospitals instead of ASCs.[253] The ASC payment structure has not been updated since 1990, and this has led to fee schedules for ASCs that are relatively crude compared to those of the hospital outpatient departments.[254] This leads to a significant payment difference for services performed at a hospital rather than at an ASC for the same DRG.[255] The recommended changes would better reflect the amount of resources necessary to complete these procedures regardless of where they are performed. CMS believes these reforms would discourage physicians from forming

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[248] MedPAC Report, *supra*, note 2, at 26.
[249] *Id.*
[250] HHS Final Report, *supra*, note 120 at 14; MedPAC Report, *supra*, note 2, at 35-44.
[251] 71 Fed. Reg. 47870, 47882-47883; HHS Final Report, *supra*, note 120 at 15-16, 64; MedPAC Report, *supra*, note 2, at 35-44.
[252] HHS Final Report, *supra*, note 120 at 16, 64; MedPAC Report, *supra*, note 2, at 36.
[253] HHS Final Report, *supra*, note 120 at 16, 64; MedPAC Report, *supra*, note 2, at 36.
[254] HHS Final Report, *supra*, note 120 at 16.
[255] *Id.*

specialty hospitals merely to take advantage of the higher payment rates for hospital services.[256]

Therefore, CMS has proposed major revisions to the ASC payment system and expects to have them implemented by 2008.[257] The proposed revisions more closely align payments for services performed in an ASC and those performed on an outpatient hospital basis.[258] This will encourage the most efficient and appropriate choice of outpatient settings for ambulatory surgery.[259] The 2007 Outpatient Prospective Payment System (OPPS) Final Rule makes final two statutory mandates from the DRA that will affect ASCs in 2007.[260] First, CMS is adding 19 procedures to the ASC list, which will now be updated at least every two years.[261] In addition, CMS will require that Medicare payment for surgical procedures performed in ASCs not exceed the Medicare payment for the same procedures when they are performed in a hospital outpatient department under the OPPS.[262] This provision will result in decreased payment for approximately 280 procedures on the ASC list beginning January 1, 2007.[263]

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[256] *Id.*
[257] CMS Ambulatory Surgical Center Payment System and CY 2008 Payment Rates, 71 Fed. Reg. 49506 (August 23, 2006); *See also* CMS Proposes Changes to Policies and Payment for Outpatient Services, Medicare News, Press Release (August 8, 2006). (http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=1938).
[258] *Id.*
[259] *Id.*
[260] *See* Final Changes to the Hospital Outpatient Prospective Payment System and CY 2007 Payment Rates, CMS-1506-FC, 743 (http://www.cms.hhs.gov/HospitalOutpatientPPS/Downloads/CMS1506FC.pdf); CMS Announces Changes To Policies And Payment For Outpatient Services, Medicare News, Press Release (November 1, 2006) (http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=2042).
[261] *Id.*
[262] *Id.*
[263] *Id.*

3. Payment System Reform #3: Definition Of A Hospital

The third recommendation was to more closely scrutinize whether an entity meets the definition of a hospital.[264] A hospital is defined as being "primarily engaged" in the provision of inpatient care.[265] CMS believes that some specialty hospitals are concentrating on the provision of outpatient services, much like ASCs, and therefore do not meet this definition.[266] Not meeting this definition could mean the denial or termination of provider agreements.[267] However, HHS stopped short of defining "primarily engaged" and will instead rely on CMS to determine on a case-by-case basis whether a hospital meets this definition.[268]

4. Payment System Reform #4: Medicare Participation

The final recommendation by MedPAC was to review the procedures for participation in Medicare.[269] CMS needs to be assured that the specialty hospitals are meeting the core requirements that CMS determines are necessary for the health and safety of Medicare beneficiaries.[270] Revisions to the standards for enrolling a specialty hospital may be necessary because of how their special capabilities correspond to requirements under the Emergency Medical Treatment and Active Labor Act (EMTALA).[271]

CMS has also proposed in the 2007 PPS rule that all hospitals (including specialty hospitals) with specialized capabilities must accept appropriate transfers, regardless of

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[264] *Id.* at 17.
[265] 42 U.S.C. §1395x.
[266] HHS Final report, *supra*, note 120, at 17; 42 U.S.C. §1395x.
[267] HHS Final report, *supra*, note 120, at 17.
[268] *Id.* at 79.
[269] *Id.*
[270] *Id.*
[271] *Id.*

whether that hospital has an ED.[272] However, CMS stopped short of recommending to Congress that all hospitals must have an emergency department, as a condition of Medicare participation that all hospitals have an emergency department.[273]

ii. Solution Prong #2: Better Align Physician and Hospital Incentives

HHS also believes that better aligning physician and hospital incentives will reduce physicians' motivation to form specialty hospitals.[274] The current payment systems for hospitals and physicians are typically at odds with each other.[275] Hospitals attempt to minimize the resources utilized in rendering treatment in order to maximize profitability under the DRG prospective payment system.[276] Physicians, on the other hand, are motivated to provide more services by the fee-for-service payment system.[277] Specialty hospitals, because they are physician-owned, do not have divergent incentives; the physician benefits from both preserving resources and providing more services.[278]

However, HHS believes that physician ownership is not the only way to align the incentives of hospitals and physicians.[279] HHS has proposed three ways to better align physician and hospital incentives: gainsharing, value-based purchasing, and hospital-

[272] *Id.* at 19; 71 Fed. Reg. 47870, 48413.
[273] *See* 71 Fed. Reg. 47870, 48413.
[274] HHS Final report, *supra*, note 120, at 64.
[275] *Id.*
[276] *Id.*
[277] *Id.*; Although neither of these influences may impact the ethical provision of those services that are medically necessary, the potential motivation is present and could be taken advantage of by those providers who are ethically challenged.
[278] *Id.* at 65.
[279] *Id.* at 65-66.

physician quality demonstration programs.[280] Utilizing these measures could help eliminate the divergence of hospital and physician utilization incentives.[281]

Gainsharing generally refers to an agreement between the hospital and physician to share savings realized from cost reduction practices.[282] The DRA authorized CMS to test various gainsharing arrangements.[283] These projects will assist in determining if gainsharing can align incentives between hospitals and physicians to improve the quality and efficiency of care provided to beneficiaries and promote improved operational and financial performance of hospitals.[284] CMS solicited applications and will select six demonstration project sites.[285]

Value-based purchasing refers to a physician payment system that encourages and rewards efficiency and high quality care through avoidance of unnecessary services.[286] HHS believes Medicare needs to move away from a payment system that pays simply for more services, regardless of their quality or impact on patient health.[287] For example, oncologists are paid less for transitioning a terminal patient to palliative care and focusing on quality of life issues than for recommending and providing intensive procedures even if the side effects of those procedures are significant and the benefits negligible.[288] A value-based purchasing system would address this problem and reduce

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[280] *Id.*
[281] *Id.* at 65.
[282] *Id.*; *See also* Gainsharing Arrangements: Hearing of the H. Ways and Means Comm., Subcomm. on Health, 109th Cong. (2005) (statement of Lewis Morris, Chief Counsel to the Inspector Gen., U.S. Dept. Health and Human Services).
[283] Deficit Reduction Act of 2005, § 5007 109 P.L. 171, 120 Stat. 4 (2006).
[284] DRA 5007 Medicare Hospital Gainsharing Demonstration Solicitation, 71 Fed. Reg. 54664 (September 18, 2006).
[285] *Id.*
[286] Value-Based Purchasing for Physicians Under Medicare: Hearing Before the H. Ways and Means Comm., Subcomm. On Health, 109th Cong. (2005) (statement of Mark B. McClellan, Administrator, Centers for Medicare and Medicaid Services).
[287] *Id.*
[288] *Id.*

incentives to order unnecessary services.[289] In addition, the payment system would reward physicians who actively prevent readmissions for patients with heart failure or diabetes.[290] The DRA requires CMS to implement a value-based purchasing system by 2009.[291]

Lastly, the MMA authorized HHS to establish a 5-year program to administer demonstration projects that examine health delivery factors that encourage the delivery of improved quality in patient care.[292] These programs may include proposals for the use of alternative payment systems for Medicare that are designed to encourage the delivery of high quality care or streamline Medicare documentation and reporting requirements.[293]

iii. Solution Prong #3: Issue Guidance On Patient Safety Measures

HHS also intends to issue guidance on patient safety measures, including specialty hospital emergency department requirements, EMTALA applicability to specialty hospitals, and minimum standards for patient safety.[294] HHS believes that there is some confusion regarding emergency department requirements as they relate to Medicare conditions of participation for hospitals.[295] Although many specialty hospitals do not provide emergency services, HHS will issue further guidance on their responsibilities with respect to appraisal, initial treatment and, when appropriate, referral of patients with medical emergencies.[296]

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[289] *Id.*
[290] *Id.*
[291] Deficit Reduction Act of 2005, § 5001 (b), 109 P.L. 171, 120 Stat. 4 (2006).
[292] Medicare Prescription Drug, Improvement, and Modernization Act of 2003, § 646, 108 P.L. 173, 117 Stat. 2066 (2004) (amending 42 U.S.C. § 1395cc-3).
[293] *Id.*
[294] HHS Final report, *supra*, note 120, at 65.
[295] *Id.* at 66-67.
[296] *Id.* at 67.

Further, in regards to applicability of EMTALA to specialty hospitals, HHS has included a provision in the 2007 inpatient PPS final rule requiring specialty hospitals to accept appropriate transfers of unstable patients when these patients require the specialized capabilities of that particular hospital.[297] Lastly, HHS stated that the Office of the Inspector General (OIG) is studying patient care and safety concerns in physician-owned specialty hospitals, focusing on whether such hospitals have minimum standards in place to ensure patient safety and the extent to which OIG has documented concerns regarding patient care and safety at these hospitals.[298]

iv. Solution Prong #4: Promote Transparency In Investment

HHS also believes that promoting transparency in investment in specialty hospitals will eliminate many of the incentives physicians have to invest in specialty hospitals by exposing fraudulent and abusive practices.[299] Therefore, HHS will exercise its authority under Section 1877(f) of the Social Security Act to require disclosure of information concerning an entity's ownership, investment, and compensation arrangements, thereby promoting more transparency within the investment structure surrounding specialty hospitals.[300] However, HHS is not limiting its inquiry to specialty hospitals, and will soon require disclosure of the financial structure of all hospitals in the program.[301] This will better enable enforcement agencies to spot suspect arrangements.[302]

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[297] *Id.*; 71 Fed. Reg. 47870, 48143 (codified at 42 C.F.R. § 489.24(f) (2006)).
[298] HHS Final report, *supra*, note 120, at 67.
[299] *See id.* at 68.
[300] *Id.*; 42 U.S.C. § 1395nn (f) (2006).
[301] HHS Final report, *supra*, note 120, at 68.
[302] *Id* at 68-69.

In addition, HHS is exploring whether to require hospitals to disclose to patients any financial relationship with physicians who refer to the hospital.[303] This is in response to the concern that physician ownership leads to increased utilization.[304] Although HHS does not believe this disclosure will have any effect on utilization, they believe a well-educated consumer can have a profound effect on the quality and efficiency of the healthcare system.[305] Lastly, HHS will propose changing the current enrollment form to distinguish between specialty hospitals and other hospitals.[306] The form will include a definition of specialty hospital and will include criteria for distinguishing in which type of specialty the hospital is involved.[307] This will enable HHS to more easily identify specialty hospitals so that their investment structure can be more closely studied.[308]

v. Solution Prong #5: Enforce Current Fraud and Abuse Laws

HHS will also focus more attention on enforcement of fraud and abuse laws as a solution to solving the specialty hospital problem.[309] HHS believes that transparency of investments in specialty hospitals could lead to the discovery of financial arrangements that violate federal law.[310] Therefore, HHS will work with the OIG to enforce, among others, the Stark self-referral statute and the Federal Anti-Kickback Statute.[311] HHS identified several situations that may arise in structuring specialty hospital that are

[303] *Id.* at 69.
[304] *Id.*
[305] *Id.* at 69-70.
[306] *Id.* at 70.
[307] *Id.*
[308] *See id.* at 68-70.
[309] *Id.*
[310] *Id.*; *See* 42 U.S.C. § 1395nn (2006).
[311] *See* HHS Final report, *supra*, note 120, at 70-77; 42 U.S.C. § 1395nn; 42 U.S.C. § 1320a-7b (b) (2006).

violations of federal law, such as disproportionate returns on investments and non-*bona fide* investments.[312]

Disproportionate returns occur when a physician receives a return on investment that does not correlate to his investment.[313] The difference between the investment made and the disproportionate return may violate the Stark self-referral statute and the Anti-kickback statute.[314] Any distribution that varies based on the physician-investors' amount of referrals violates these laws.[315] In addition, any compensation arrangement the physician has with the specialty hospital may be a violation if it does not fit within an exception or safe harbor.[316] HHS believes it can interpret the regulations as meaning that only true profit distributions and dividends paid to physician-investors are excused from having to meet a compensation arrangement exception.[317]

Non-bona fide investments arise in numerous situations.[318] HHS considers investments to be bona fide when the physician-investor investment is truly at risk such as in an arms-length loan.[319] No-interest loans to physicians when investing in specialty hospitals are not bona fide investments.[320] Further, investment loans that are guaranteed by others are not bona fide investments.[321] In addition, HHS will examine how specialty hospitals are selecting and retaining physician-investors.[322] Selecting and retaining

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[312] HHS Final report, *supra*, note 120, at 70.
[313] *Id.*
[314] *Id.*; 42 U.S.C. § 1395nn; 42 U.S.C. § 1320a-7b (b).
[315] *See* HHS Final report, *supra*, note 120, at 70-73.
[316] *Id.* at 71.
[317] *Id.* at 71.
[318] *Id.* at 70.
[319] *See id.* at 71.
[320] *Id.*
[321] *Id.*
[322] *Id.* at 73.

physician-investors in relation to their referrals to the specialty hospital violates both the Stark and Anti-kickback statutes.[323]

Taken together, the changes proposed by HHS could have a profound effect on the concerns regarding specialty hospitals.[324] The payment system changes will reduce the financial incentives physician-owners have in creating specialty hospitals.[325] In addition, these changes will align physician and hospital incentives and thereby create additional incentives to keep physicians from competing with established hospitals.[326] Patient safety will be increased due to the clarification of emergency department regulations.[327] Lastly, discovery of fraud and abuse within the healthcare system will become easier through increased transparency of investment structure.[328]

Whether Georgia should completely eliminate the CON program mostly depends on the effectiveness of the outlined changes. These changes are a step in the right direction, but will they be enough to control the adverse financial effects specialty hospitals could create for community hospitals? HHS is attempting to eliminate the problem by reducing the financial incentives to create these hospitals. These changes may have a profound effect on the profitability of specialty hospitals; however, the effects of these changes will not be discernable for at least a few years. If further changes are in order, HHS will most likely revisit the issue. In the meantime, community hospitals will continue to feel the effects of losing the most profitable patients to their competitors.

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[323] *See id.* at 70-72.
[324] *Id.* at 79-80.
[325] *Id.*
[326] *Id.*
[327] *Id.*
[328] *Id.*

e. How Do These Changes in Federal Law Affect Georgia's CON Debate?

Unfortunately, it does not appear Georgia's legislature will wait until the specialty hospital problem is concluded before pulling the plug on CON.[329] The General Assembly is lining up for a legislative battle for the 2007 session.[330] Currently, no specialty hospitals, as defined by HHS, are located in Georgia.[331] However, the premature elimination of CON in Georgia could see a proliferation of specialty hospitals like those experienced in other states without CON.[332]

IV. Proposal

Due to the differing opinions regarding the effect of eliminating CON, Georgia should consider a scaled back approach to complete elimination of CON. Partial deregulation of CON would enable the legislature to examine the expansion of health services and its effect on the health care market in Georgia prior to proceeding with complete CON elimination. Further, partial deregulation would give existing hospitals a chance to adjust to the changes. This approach has been attempted by other states.[333]

Proponents of CON in Georgia wish to maintain CON to block the entry of specialty hospitals.[334] It is not competition they are afraid of; it is "unfair"

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[329] *See* Preserving CON, *supra*, note 79, at 13; *Healthcare's Legal Monopoly*, WALB News (November 13, 2006, *available at* http://www.walb.com/Global/story.asp?S=5657491&nav=5kZQ); *'High Noon' For Health Care*, The Moultrie Observer, November 3, 2006, *available at* http://www.moultrieobserver.com/local/local_story_307222239.html.
[330] *See id.*
[331] HHS Final report, *supra*, note 120, at Appendix II, Table 1; *But see* Geographic Location, *supra*, note 120, at 12, Figure 2 (noting 1-2 specialty hospitals in Georgia).
[332] Geographic Location, *supra*, note 120, at 4, 12.
[333] *See* Patrick Powers, Pros and Cons: Debating Healthcare Facility Regulation, HealthLeaders-Interstudy, 4 (October 2006), *available at* http://home.healthleaders-interstudy.com/#.
[334] *See, e.g.,* Call to Action, *supra*, note 122, at 2; Preserving CON, *supra*, note 79, at 13.

competition.[335] If this is true, a proposal allowing for entry of providers should not be objectionable as long as specialty hospitals continue to be regulated by the State.

Currently, Georgia regulates eleven types of facilities, nineteen procedures, and eight equipment expenditures.[336] The proposal outlined herein would continue the CON process, but exempt free-standing, non-office based, multi-specialty ambulatory surgical centers. The proposal also includes amending CON to specifically include specialty hospitals within the definition of "hospital".[337] The same "needs based" analysis would be used to determine whether a specialty hospital is issued a CON. In addition, this proposal would eliminate need analysis for certain health care facilities and health services. Deregulation of ambulatory surgery centers would enable the General Assembly to study the effects of competition on community hospitals without creating competition for all services. This would allow the federal government time to determine the fate of physician ownership in whole hospitals without prematurely opening up Georgia to the alleged unfair competition created by specialty hospitals.

a. Current ASC Market in Georgia

Currently, Georgia allows an exemption from the CON process for ASCs that are physician-owned, part of a single physicians' group, office-based, and single-specialty.[338] This exception originated from a 1987 revision in the Georgia State Health Plan for Ambulatory Surgery Services as a way for physicians who had been providing outpatient surgery services within their offices to be classified as physician-owned, limited purpose ambulatory surgery centers so that they could receive Medicare facility fee

[335] *See, e.g.,* Call to Action, *supra*, note 122, at 2; Preserving CON, *supra*, note 79, at 13.
[336] *See* Ga. Code Ann. §31-6-40; Testimony of S. Houston Payne, State Commission on the Efficacy of Certificate of Need (August 8, 2005) (hereinafter S. Houston Payne).
[337] *See* Final Report, *supra,* note 120, at 1.
[338] Ga. Code Ann. § 31-6-47.

reimbursement for their services.[339] As mentioned, there is a threshold expenditure for such a facility and a requirement that the facility receive a letter of non-reviewability; however, this is a far easier and less costly process than obtaining a CON.[340] Whereas these office-based ASCs are not regulated by CON, free-standing multi-group ambulatory surgery centers, single specialty or multi-specialty, are regulated by Georgia's CON program.[341] This disparity is not consistent with CON's underlying theory of cost containment.

The CON process was created to limit the amount of money that healthcare providers spend on creating new services or facilities.[342] However, if a single physician wants to spend upwards of $1.5 million on a new office surgery room, there is no regulation.[343] Therefore, instead of enabling physicians to pool resources to build one area facility in which multiple physicians in multiple specialties may perform ambulatory procedures, the CON program provides an incentive for every physician to spend $1.5 million on a surgery facility of his own.

This is exactly what is currently happening in Georgia.[344] There are more than 230 licensed ASCs in Georgia.[345] Most of these were created pursuant to the exemption.[346] Allowing physicians who desire to form an ASC to pool resources would enable them to better address quality concerns through increased capital. Of course, this

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[339] *See* Health Strategies Council, Georgia State Health Plan, Component Plan for Ambulatory Surgery Services, 3 (June 1998) (hereinafter ASC Component Plan) *available at* http://dch.georgia.gov/vgn/images/portal/cit_1210/16/37/32755444Ambulatory%20Surgery.pdf.
[340] *Compare* Ga. Code Ann. § 31-6-40 and Ga. Code Ann. § 31-6-47; *See, also,* Testimony of Deborah J. Winegard, State Commission on the Efficacy of Certificate of Need, at 7 (August 8, 2005) (hereinafter Deborah J. Winegard).
[341] Ga. Code Ann. § 31-6-40.
[342] *See* 42 U.S.C. 300k *et seq.* (repealed), 93 P.L. 641, 88 Stat. 2225.
[343] *See* Ga. Code Ann. § 31-6-47 (a)(4); Ga. Code Ann. § 31-6-2 (14)(G), (H).
[344] *See* Testimony of Robert Stuenkel, State Commission on the Efficacy of Certificate of Need, at 8 (August 8, 2005) (hereinafter Stuenkel).
[345] *Id.*
[346] *Id.*

assumes that a large facility with, for example, ten rooms can be built for less money than ten separate facilities with one room each. Further, one facility would require less staff and supply, thereby reducing costs and mitigating any reduction in nursing staff that may be caused by the entry of an additional facility into the market. But what effect would this have overall on existing hospitals? This question has been previously addressed.[347]

b. Concerns About ASCs

Hospitals may complain that physician ownership in an ASC creates many of the same problems that specialty hospitals create. However, there is evidence that ASCs are beneficial to the healthcare industry.[348] Hospitals usually cite the prospect of hospital closure as a reason for disallowing ASCs; however, hospital closures decreased between 1987 and 1994, during which time the number of ASCs doubled.[349] ASCs are usually able to charge less for procedures that could be performed at hospital outpatient facilities.[350] This is attributed in part to ASCs' failure to provide as much indigent care, but is also attributed to the high overhead for which hospitals must account.[351] ASCs are generally considered more convenient than hospitals.[352] Further, physicians consider ASCs a recruitment tool that provides an incentive for physicians to relocate to an area, benefiting the patients in those areas and the economy.[353]

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[347] ASC Component Plan, *supra*, note 360, at 3.
[348] *See* S. Houston Payne, *supra,* note 336, at 4 (citing *Does Ambulatory Surgery Center development Cause Hospital Closure?,* Outpatient Surgery, 1 (October 1997); *See* Stuenkel, *supra*, note 344 at 8.
[349] *See* S. Houston Payne, *supra,* note 336, at 4 (citing *Does Ambulatory Surgery Center development Cause Hospital Closure?,* Outpatient Surgery, 1 (October 1997).
[350] Mark Taylor, Hospitals Cry Foul, Modern healthcare, 10 (February 17, 2003) (citing Payment for Procedures in Outpatient Departments and Ambulatory Surgical Centers, U.S. Department of health and human Services, Office of Inspector General, January 2003, *available at* http://oig.hhs.gov/oei/reports).
[351] *Id.*
[352] *See, e.g.,* John Bagnato, General Surgery, Ambulatory Surgery Centers – A Battle Ahead, J. Med. Assoc. Ga., 18.
[353] Deborah J. Winegard, *supra*, note 340, at 4.

Another concern regarding ASCs is that they may not provide the same quality of care as hospitals.[354] However, there are measures in place to monitor quality in these facilities.[355] The Office of Regulatory Compliance (ORC) requires ASCs to develop and implement policies and procedures to ensure that the outpatient care provided meets the needs of patients in accordance with generally accepted standards of practice.[356] Further, the facility must be staffed with sufficient qualified personnel to promptly, safely, and effectively meet the care needs of patients.[357] Also, the facility must assign responsibility for the periodic assessment of the quality and effectiveness of the outpatient services provided.[358] Lastly, ORC requires certain outpatient service delivery standards with which ASCs must comply.[359] Contrary to this concern, ASCs may even enhance quality.[360] Both the federal and state governments have encouraged the development of ASCs as a cost savings measure that maintains or enhances quality.[361]

c. TAC Findings Regarding ASCs

In 1995, the Georgia Health Strategies Council created a technical advisory committee (TAC) to study regulatory changes in the Ambulatory Surgery Services Component Plan and the Certificate of Need Rules.[362] This study recommended the development of a plan and rules that would not include specific numerical need formula

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[354] *See* Stuenkel, *supra*, note 344, at 9.
[355] *See* Ga. Comp. R. & Regs. r. §290-9-7-.32.
[356] Ga. Comp. R. & Regs. r. §290-9-7-.32.
[357] *Id.*
[358] *Id.*
[359] *Id.*
[360] S. Houston Payne, *supra,* note 336, at 5 (citing Does Ambulatory Surgery Center Development Cause Hospital Closures?, Outpatient Surgery, 1 (1997)); *See* Health Strategies Council, Georgia State Health Plan, Component Plan for Ambulatory Surgery Services, 3 (June 1998) (hereinafter ASC Component Plan) *available at* http://dch.georgia.gov/vgn/images/portal/cit_1210/16/37/32755444Ambulatory%20Surgery.pdf.
[361] S. Houston Payne, *supra,* note 336, at 5 (citing Does Ambulatory Surgery Center Development Cause Hospital Closures?, Outpatient Surgery, 1 (1997)); *See* ASC Component Plan, *supra*, note 360, at 3.
[362] *See* ASC Component Plan, *supra,* note , at 3.

or definition of capacity, but would continue to address the public objectives of access and quality.[363] This resulted from the belief that ambulatory surgery services are a low-cost alternative to inpatient surgery services in Georgia, and that market forces, including a competitive environment, the large number of existing providers, and the growing presence of managed care, are in place in urban areas to control excess investment.[364] The TAC's plan was also based on the belief that healthcare regulation should be compatible with the current healthcare market place so that economic realities can co-exist with regulation.[365]

Due to public concerns regarding the lack of numerical need methodology, the Agency decided not to adopt the TAC's initial rules recommendation.[366] Instead, the Council reformed the TAC and created a plan that took into account numerical need methodology and other need criteria.[367] Similarly, the proposal outlined in this paper would eliminate this need analysis. However, as mentioned in the TAC's proposal, the quality and access analysis would remain, continuing to be run through the CON process.

The CON quality standards for ASCs include a credentialing process that ensures the physicians only perform those procedures that are defined within the scope of the their license and encourages limiting the privileges of a surgeon within the ASC to only those for which he/she is granted by an accredited hospital.[368] Also included is a standard requiring licensure by the state and accreditation by JCAHO or the Accreditation Association for Ambulatory Health Care (AAAHC).[369]

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[363] *Id.*
[364] *Id.* at 4.
[365] *Id.*
[366] *Id.*
[367] *Id.*; *See* Ga. Code Ann. §31-6-47 (2006); Ga. Comp. R. & Regs. r. §111-2-2-.40 (2006).
[368] Ga. Comp. R. & Reg. r. 111-2-2-.40; ASC Component Plan, *supra*, note 360, at 13.
[369] Ga. Comp. R. & Reg. r. 111-2-2-.40; ASC Component Plan, *supra*, note 360, at 14.

In regards to access, the current CON process requires CON recipients to provide indigent healthcare.[370] The DCH may require that any CON applicant commit to provide a specified amount of clinical health services to indigent or charity, Medicare, Medicaid, PeachCare, and similar patients as a condition for the grant of a CON.[371] Violators of these agreements are liable to the DCH for a monetary penalty in the amount of the difference between the amount of services so agreed to be provided and the amount actually provided.[372]

Even though this proposal would maintain the above parts of the CON analysis, hospitals may not find this proposal palatable due to the prospect of losing an existing stream of income. However, if the CON program is amended to conform to this proposal, proactive hospitals can capture some of the revenues from these ASCs by utilizing innovative delivery systems like physician-hospital ancillary joint ventures.

V. Physician-Hospital Ancillary Joint Ventures

Recently, joint ventures between hospitals and physicians have been used to combat the ill effects that hospitals may encounter when physicians create specialty hospitals.[373] "Joint venture" is a generic term for innovative health care delivery systems by which two or more entities join forces to jointly offer services as one entity.[374] "Ancillary" joint ventures are those joint ventures constituting by attribution no more than an insubstantial portion of the total activities of the participants.[375] These

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[370] *See* Ga Code Ann. §31-6-40.1; Ga. Comp. R. & Regs. r. §111-2-2-.05.
[371] *Id.*
[372] *Id.*
[373] Heard, The Specialty Hospital Debate, supra, note 169, at 225.
[374] James M. Daniel, Jr., and Kimberly H Gillespie, Structuring the Under Arrangements Joint Venture, Insights, 16 (Special Issue 2005) (hereinafter Under Arrangements Joint Ventures), *available at* http://www.willamette.com/insights_special2005.shtml.
[375] *See* David M. Flynn, CA-5 Remands St. David's But Provides Little Clarification on 'Control' in Joint Ventures, Journal of Taxation, 40, 53 (January 2004) (hereinafter Flynn).

arrangements can be structured as partnerships between the hospital and a physician's entity, or as a limited liability company.[376] The venture can take on tax-exempt properties; however, usually they are for profit.[377] These ventures have become increasingly popular among hospitals trying to recapture revenue lost due to the influx of specialty hospitals and ASCs.[378]

By jointly offering services with physicians, hospitals could reduce any effects these ASCs have on their revenue. This "if you can't beat 'em, join 'em" approach would enable the hospital to mitigate any reduction in outpatient service utilization. Of course, this may reduce the hospital's total revenue through the resulting decrease in utilization. Nonetheless, a partial interest in the ASC would enable the hospital to recapture some of its lost revenue while creating a new facility that perhaps will enhance quality. This increase in quality could draw more patients into the market and therefore increase total utilization and quite possibly increase the hospital's total revenue.[379] Further, the proper placement of the ASC could tap into a new market of patients and increase the hospital's total market share.[380]

Regardless of their corporate form, physician-hospital joint ventures can provide numerous benefits to the parties involved and the patients they serve.[381] The increased capital resulting from the inclusion of additional parties could lead to increased

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[376] *Id.*; In Georgia, a "partnership" is an association of two or more persons to carry on as co-owners a business for profit, Ga Code Ann. §14-8-6 (2006); A "limited liability company" is a state-specific corporate form that typically can have properties of a partnership or a corporation according to the organizer's desires, *see* Ga Code Ann. §14-11-100 *et seq.* (2006).
[377] Eileen M. Newell, Comment: healthcare Joint Ventures: Pushing Tax-exempt law to the Limit, 18 J. Contemp. Health L. & Pol'y 467, 482-483 (2002).
[378] Under Arrangements Joint Ventures, *supra*, note 374, at 16.
[379] *See* Craig E. Holm, Satellite Centers Help Academic Facilities Tap Outpatient Market, Health Care Strategic Management, 7 (November 1992).
[380] *Id.*
[381] *See* Scott Becker *et al*, Ambulatory Surgery Center Joint Ventures Involving Tax-Exempt Entities, J. Health Care Finance, 47 (Summer 1999) (hereafter Becker).

technology.[382] Also, the parties are able to reduce their risk by spreading it out among more parties.[383] By involving the physicians in the ownership of the ASC, the hospital can ensure the physicians' concern for improving quality in the services provided.[384]

As discussed, there are numerous advantages to forming a physician-hospital ASC.[385] However, the formation of this type relationship also can create numerous pitfalls.[386] Two areas in which hospitals and physicians should be concerned are the health care fraud and abuse implications of the resulting financial arrangement.[387] In addition, a tax-exempt hospital should be concerned about how this venture will affect the hospital's tax-exemption.[388]

a. Fraud and Abuse Concerns

The physician-hospital ASC can implicate health care fraud and abuse laws.[389] The financial arrangement between the hospital and the physicians implicate both the federal anti-kickback statute and the Stark self-referral prohibition.[390] However, if structured properly, the venture should not violate these statutes because of the physician-hospital ASC safe harbor and certain Stark exceptions.[391]

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[382] *Id.*
[383] *Id.*
[384] *Id.*
[385] *See id.*
[386] *See id.*; *See* Final Report, *supra,* note 120, at 73.
[387] *See* Final Report, *supra,* note 120, at 73.
[388] *See* Becker, *supra*, note 381, at 47.
[389] *See* Final Report, *supra,* note 120, at 73.
[390] *See* 42 U.S.C. 1320a-7b(b) (2006); 42 U.S.C. §1395nn.
[391] OIG Supplemental Compliance Program Guidance for Hospitals, 70 Fed. Reg. 4858, 4865 (January 31, 2005) (hereafter OIG Compliance Guidance); 42 CFR § 411.355 (2006); 42 CFR § 411.351 (2006).

i. Stark Self-Referral Prohibition

The OIG believes that joint ventures generally are subject to risks involving referrals that may be illegal under the Stark self-referral prohibitions.[392] Physicians and hospitals should be concerned about the Stark self-referral statute when creating any financial relationship with an entity or person to which a referral may be made.[393] As mentioned, if a physician has a financial relationship with an entity, then the physician may not make a referral for the provision of designated health services.[394] However, designated health services do not include most services provided at ASCs, and are therefore not usually subject to the self-referral restriction.[395] Further, there is an exception at for prosthetics, prosthetic devices, and durable medical equipment implanted during a procedure performed in a Medicare-certified ASC by the referring physician or a member of the referring physician's group practice, if the arrangement for the furnishing of the implant does not violate the anti-kickback statute.[396]

ii. Anti-Kickback Implications

In addition, the arrangement between the hospital and physician could implicate the federal anti-kickback statute.[397] The anti-kickback statute prohibits knowingly and fully soliciting, receiving, offering, or paying anything of value to induce referrals of items or services payable under any federal health care program.[398] These payments, or "kickbacks", are harmful because they distort medical decision-making, cause over-utilization, increase costs to the federal health care programs, and result in unfair

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[392] *Id.*; *see* 42 U.S.C. §1395nn; *see* 42 U.S.C. §1320a-7b(a).
[393] *See* 42 U.S.C. §1395nn.
[394] *See id.*
[395] *See* 42 CFR § 411.351.
[396] 42 CFR § 411.355.
[397] *See* 42 U.S.C. 1320a-7b(b).
[398] 42 U.S.C. 1320a-7b(b).

competition by freezing out competitors that are unwilling to pay kickbacks.[399] The physicians and the hospital can both be found liable for their involvement in a joint venture that is in violation of the Anti-Kickback statute.[400]

One chief concern cited in the HHS Final Report was that remuneration from a joint venture might be disguised payment for past or future referrals from an investor to the venture or from one investor to another.[401] The OIG has identified three areas hospitals should examine when forming a joint venture: (1) the manner in which joint venture participants are selected and retained; (2) the manner in which the joint venture is structured; and (3) the manner in which the investments are financed and profits distributed.[402] Within each area, OIG has identified particularly suspect features.[403] The identification as "suspect" does not mean it is necessarily illegal or unlawful, or that it cannot be properly structured to fit in a safe harbor.[404] The practice or activity may also be considered beneficial from a clinical, cost, or other perspective, but yet still considered suspect.[405] This does not mean, however, that the activity is per se illegal.[406]

1. Investor Selection

Using the new transparency of investment regulations, the OIG will look closely at the manner in which joint venture participants are selected and retained.[407] If a joint venture has a substantial number of participants in a position to make or influence

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[399] Publication of OIG Special Advisory Bulletin on Contractual Joint Ventures, 68 Fed. Reg. 23148 (April 30, 2003) (hereafter JV Advisory Bulletin 03).
[400] *Id.*; *See* 42 U.S.C. 1320a-7b(b).
[401] OIG Compliance Guidance, 70 Fed. Reg. at 4865; Final Report, *supra,* note 120, at 74; *See* 42 U.S.C. §1320a-7b(a); Final Report, *supra,* note 120, at 73.
[402] OIG Compliance Guidance, 70 Fed. Reg. at 4865; Final Report, *supra,* note 120, at 73.
[403] OIG Compliance Guidance, 70 Fed. Reg. at 4865; Final Report, *supra,* note 120, at 73.
[404] OIG Compliance Guidance, 70 Fed. Reg. at 4865.
[405] *Id.*
[406] *Id.*
[407] Final Report, *supra,* note 120, at 73-74.

referrals to the venture, other participants, or both, the OIG will view the joint venture as suspect.[408] Joint venture organizers should not offer a greater or more favorable investment or business opportunity to those involved in the joint venture than that made to those anticipated to make fewer referrals.[409] Physician members should not be actively encouraged or required to make referrals to the joint venture.[410] Additionally, physicians should not be encouraged or required to divest their ownership interest if they fail to sustain a certain level of referrals.[411] The venture should not distribute to members the results of any referral tracking system.[412] Investment interests should remain transferable and should never be subject to transfer restrictions related to referrals.[413]

2. Corporate Structure

The OIG will also closely scrutinize the corporate structure of the joint venture.[414] A venture may be suspect if one of its participants is already engaged in the line of business to be conducted by the joint venture, and that participant will own all or most of the equipment, provide or perform all or most of the items or services, or take responsibility for all or most of the day-to-day operations, while other participants primarily contribute a captive referral base.[415] In our situation, the hospital is already engaged in providing outpatient surgery. Therefore, the venture should be cognizant of the remaining factors. Capitalization of the venture should be proportional for each investor requiring the physicians to contribute more than a captive referral base.

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[408] OIG Compliance Guidance, 70 Fed. Reg. at 4865; Final Report, *supra,* note 120, at 73.
[409] OIG Compliance Guidance, 70 Fed. Reg. at 4865; Final Report, *supra,* note 120, at 73.
[410] OIG Compliance Guidance, 70 Fed. Reg. at 4865; Final Report, *supra,* note 120, at 73.
[411] OIG Compliance Guidance, 70 Fed. Reg. at 4865; Final Report, *supra,* note 120, at 73.
[412] OIG Compliance Guidance, 70 Fed. Reg. at 4865; Final Report, *supra,* note 120, at 74
[413] OIG Compliance Guidance, 70 Fed. Reg. at 4865; Final Report, *supra,* note 120, at 74.
[414] OIG Compliance Guidance, 70 Fed. Reg. at 4865; Final Report, *supra,* note 120, at 74.
[415] OIG Compliance Guidance, 70 Fed. Reg. at 4865; Final Report, *supra,* note 120, at 74.

3. Financing and Distributions

The OIG will also consider the manner in which the investments in joint ventures are financed and profits are distributed.[416] Physicians' investments should never be guaranteed nor should physicians be able to borrow funds from another participant in order to finance the investment.[417] Further, the venture should distribute revenues in proportion to the investment interests of the participants.[418]

iii. Anti-Kickback Safe Harbor

The OIG believes that joint ventures generally are subject to risks involving remuneration that may be illegal under the Federal Anti-Kickback statute.[419] Whenever possible, hospitals and physicians should structure their ventures to satisfy one of the Anti-kickback safe harbors.[420] However, liability ultimately turns on intent.[421] To qualify for safe harbor protection, an arrangement that would otherwise violate the Anti-Kickback statute must fit squarely in one of the safe harbors.[422] One such Safe harbor is the Physician-Hospital ASC.[423]

The Physician-Hospital ASC safe harbor includes conditions addressing the three areas the OIG has noted as areas for concern.[424] An investor may not be afforded better investment terms based on past or expected referrals or amounts of services furnished to

[416] OIG Compliance Guidance, 70 Fed. Reg. at 4865; Final Report, *supra,* note 120, at 74.
[417] OIG Compliance Guidance, 70 Fed. Reg. at 4865; Final Report, *supra,* note 120, at 74.
[418] OIG Compliance Guidance, 70 Fed. Reg. at 4865; Final Report, *supra,* note 120, at 74.
[419] OIG Compliance Guidance, 70 Fed. Reg. at 4865; Final Report, *supra,* note 120, at 74; *See* 42 U.S.C. §1320a-7b(a).
[420] *See* 42 U.S.C. §1320a-7b(a); *see, also,* Final Report, *supra,* note 120, at 74.
[421] In most jurisdictions, specific intent is not required to prove the person knowingly and willfully offered any remuneration, however, the Ninth Circuit has a more narrow interpretation, United States v. Starks, 157 F.3d 833, 838 (11th Cir. 1998); Hanlester Network v. Shalala, 51 F.3d 1390, 1400 (9th Cir. 1995).
[422] JV Advisory Bulletin 03, 68 Fed. Reg. at 23148.
[423] Final Report, *supra,* note 120, at 75.
[424] *Id.*; *see, also,* 42 C.F.R. §1001.952(r)(4) (2006).

the entity.[425] The entity cannot loan funds to or guarantee a loan for an investor if an investor uses any part of the loan to purchase interest in the entity.[426] Distributions made by the entity to the investors must be directly proportional to the capital investment made by the investor.[427] The entity and the physician-investor must treat federal health care program beneficiaries in a nondiscriminatory way.[428] The entity may not lease space from a hospital or use equipment owned by the hospital unless the arrangement satisfies the relevant safe harbors regarding space rental, equipment rental, and the personal services and/or management contracts.[429] All ancillary services performed at the entity must be directly and integrally related to the primary procedures performed at the entity, and none may be separately billed to a federal health care program.[430] The hospital cannot report any costs associated with the ASC.[431] Lastly, the hospital may not be in a position to make or influence referrals directly or indirectly to any investor or entity.[432]

Engaging in conduct or entering into an arrangement that is not protected by a safe harbor and violates the Anti-Kickback statute could lead to criminal and civil liability.[433] In addition, this type of conduct or arrangement could cause tax-exemption problems for the hospital.[434] Tax-exempt hospitals must also examine how forming an ASC with a for-profit entity will affect their tax-exempt status.[435]

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[425] 42 C.F.R. §1001.952(r)(4)(i).
[426] 42 C.F.R. §1001.952(r)(4)(ii).
[427] 42 C.F.R. §1001.952(r)(4)(iii).
[428] 42 C.F.R. §1001.952(r)(4)(iv).
[429] 42 C.F.R. §1001.952(r)(4)(v); *See also* 42 C.F.R. §1001.952(b), (c), (d).
[430] 42 C.F.R. §1001.952(r)(4)(vi).
[431] 42 C.F.R. §1001.952(r)(4)(vii).
[432] 42 C.F.R. §1001.952(r)(4)(viii).
[433] *See* 42 U.S.C. §1320a-7b(b) (2006) (imposing a felony upon those found in violation); 42 U.S.C. §1320a-7a (2006) (imposing a civil monetary penalty for violating the anti-kickback statute); Violators may also be subject to liability under the Civil False Claims Act and the Criminal False Claims Act for submission of a claim that is tainted by an illegal kickback).
[434] I.R.S. G.C.M. 39,862 (1991).
[435] *See* I.R.C. § 501 (2006).

b. Tax Exemption Concerns

As mentioned, hospitals benefit from utilizing joint ventures by recapturing some of their lost revenues.[436] Increased capital and administrative expertise from the hospital are incentives for physicians to utilize this model for delivery of ASC services.[437] This seems like a win-win situation for those involved. However, many joint ventures are formed between entities that do not have the same tax status.[438] While the physicians' practices are most likely structured as for-profit, some hospitals, especially those organized under Georgia's Hospital Authority law, are tax-exempt.[439]

To qualify for the tax exemption, a hospital must be organized and operated exclusively for charitable purposes.[440] If an organization fails to meet either the organizational test or the operational test, it is not exempt.[441] An organization is organized exclusively for one or more exempt purposes only if its articles of organization limit the purposes of such organization to one or more exempt purposes, and do not expressly empower the organization to engage, otherwise than as an insubstantial part of its activities, in activities which in themselves are not in furtherance of one or more exempt purposes.[442] An organization will be regarded as operated exclusively for one or more exempt purposes only if it engages primarily in activities which accomplish an exempt purpose, if no more than an insubstantial part of its activities is not in furtherance

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[436] *See* Under Arrangements Joint Ventures, *supra,* note 374, at 16.
[437] *See* Vince Galloro, If You Can't Beat 'em, Modern Healthcare, 6 (April 3, 2006).
[438] *See* Becker, *supra*, note 381, at 47.
[439] Ga. Code Ann. §31-7-72 (2006).
[440] I.R.C. § 501(c)(3); 26 CFR 1.501(c)(3)-1 (2006); *See also* Ga. Code Ann. §48-7-25 (2006) (stating those corporations exempt under I.R.C. § 501(c)(3) are also exempt from Georgia income tax).
[441] *Id.*
[442] 26 CFR 1.501(c)(3)-1(b).

of an exempt purpose, and if no part of its net earnings inure to the benefit of private shareholders or individuals.[443]

Health care providers must meet a flexible "community benefit" test to qualify as a charitable entity.[444] To benefit a community, a charity must serve a sufficiently large and indefinite class and private interests must not benefit to any substantial degree.[445] The mere fact that a tax-exempt organization enters into an arrangement with a for-profit party that receives returns on their capital investments does not establish that the organization has impermissibly conferred private benefit.[446] The question remains whether the organization has a substantial nonexempt purpose whereby it serves private interests.[447] This issue has been addressed in *Redlands Surgical Services v. Commissioner of Internal Revenue Service*.[448]

i. *Redlands Surgical Services v. Internal Revenue Service*

In *Redlands*, the Tax Court held that a hospital failed to meet the qualifications for tax-exempt status because it ceded control over the operations of an ancillary joint venture partnership to private parties thus creating impermissible private benefit in violation of Internal Revenue Code Section 501(c)(3).[449] Redlands Surgical Services (RSS) was a non-profit entity and wholly owned subsidiary of Redlands Health Services (RHS), a non-profit hospital. RSS formed a general partnership with a for-profit surgical

[443] 26 CFR 1.501(c)(3)-1(c).
[444] Redlands Surgical Services. v. Commissioner, 113 T.C. 47 (1991), affirmed Redlands Surgical Services v.Commissioner Internal Revenue, 242 F.3d 904 (2001) (9th Cir.) (citing Sound Health Association v. Commissioner, 71 T.C. 158, 184-185 (1978)).
[445] *Redlands*, *supra*, note 444, 113 T.C. at 73.
[446] *Id.* at 74-75.
[447] *Id.* at 75.
[448] *Id.*
[449] *Id.* at 97.

physicians group (SCA) to own 61% of, and operate, an ASC.[450] The remaining 39% was owned by a for-profit management company.[451] RSS brought a declaratory judgment action to determine whether it qualified for tax exemption under I.R.C. 501(c)(3).[452]

The Court noted that the mere fact that an organization seeking exemption enters into a partnership agreement with private parties that receive returns on their capital investments does not establish that the organization has impermissibly conferred private benefit.[453] The pivotal determination is whether the organization has a substantial nonexempt purpose.[454]

The Court held that RSS was not a tax exempt entity because it ceded control of the partnership's and the ASC's activities to for-profit partners.[455] The Court cited the partnership agreement's failure to include a mutually agreed upon charitable purpose and RSS's lack of formal or informal control as indicia of for-profit control over the partnership's activities.[456] The Court identified the following problems with the structure of the entity: the for-profit interests involved had no obligation to put charitable objectives ahead of non-charitable objectives, RSS lacked voting control over the general partnership with SCA although it could block actions proposed to be taken, RSS lacked the authority to ensure charitable objectives would govern the outcome of arbitration should there be a voting deadlock, the long-term contract with the for-profit management company gave the for-profit interests control over the day-to-day operations along with a

[450] *Id.* at 48.
[451] *Id.*
[452] *Id.*
[453] *Id.* at 74-75.
[454] *Id.* at 75.
[455] *Id.* at 78.
[456] *Id.* at 78-88.

profit-maximizing incentive, the termination of quality assurance, which evidenced RSS's lack of control, the lack of ability to determine the resolution of any matter concerning the care and treatment of patients, lack of informal control, competitive restrictions placed on Redlands Hospital, and marketing advantages secured by the for-profit interests as a result of the general partnership.[457] Therefore, the Court found that RSS impermissibly served private interests that were more than insubstantial.[458] Thus, the arrangement failed the operational test.[459] The Ninth Circuit Court of Appeals affirmed the decision adopting the Tax Court's decision.[460] In so doing, the Court noted that RSS had "ceded control" over to for-profit parties.[461]

This issue of control was also the focus of another case addressing joint ventures between for-profit and non-profit health care providers, although that case involved a for-profit hospital and a non-profit hospital creating a single non-profit hospital joint venture.[462] Tax experts have considered these cases and other Revenue Rulings as evidence that ancillary joint ventures should raise no exemption concerns for the non-profit entity so long as it does not cede control to the for-profit entity.[463]

Therefore, as long as ASG is structured to be incompliance with health care fraud and abuse laws and so that the hospitals do not lose their tax-exemption, hospitals should proactively pursue ancillary joint ventures with physicians to combat or prevent the prospective loss of revenue that may occur as ASCs evolve. Notwithstanding their

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[457] *See id.*
[458] *Id.* at 78.
[459] *Id.*
[460] *Redlands*, 242 F.3d at 904.
[461] *Id.*
[462] *St. David's Health Care System v. United States*, 349 F.3d 232 (5th Cir. 2003).
[463] *See* Flynn, *supra*, note 375, at 54; *See also* Rev. Rul. 98-15, 1998-1 C.B. 718.

efforts, though, physicians may be hesitant to include a hospital in such a venture. What incentives do physicians have to include hospitals in the structure of an ASC?

VI. Incentives to Form a Physician-Hospital ASC

Thus far, we have determined that the formation of a physician-hospital ASC is a viable option for hospitals when trying to recapture the revenues lost from the establishment of an ASC in their market area. However, what will keep physicians themselves from capitalizing on the market and forming the ASC without the assistance of the local hospital? First, the question assumes that, given the chance, physicians would enter into direct competition with the local hospital without first offering the hospital an investment interest. This may not be the case in every situation. However, as discussed above, the inclusion of a non-profit hospital may require the physicians to cede control over the operations of the ASC to the hospital so that the hospital can maintain its tax exemption.[464] Thereafter, hospital decisions would be dominated by charitable objectives and not profit-maximizing objectives.[465] So why would physicians include a hospital when its inclusion could adversely affect profits?

The easiest answer is money. Hospitals typically are considered to have "deep pockets."[466] Inclusion of a hospital in the formation of an ASC could provide financial stability for the facility, enabling it to operate at peak performance and at the forefront of medical technology.[467] But physicians have sufficient financial power to form these facilities on their own.[468] Therefore, financial incentives may not be enough to convince

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[464] *See, e.g., Redlands*, 242 F.3d at 904.
[465] *See id.*
[466] This is due to their typical good financial standing within their community
[467] *See* Becker, *supra*, note 381, at 1.
[468] *See* Michael Romano, Doc Income Falling Since '95 Due to Declining Fees: Study, Modern Healthcare, 34 (July 3-10, 2006) (stating average income for physicians in 2003 was $203,000).

physicians to include hospitals. Of course, also prevents hospitals from competing with the ASC (which some have done successfully).

Any legislation that deregulates CON to allow ASCs should include additional incentives for physicians to include hospitals in the corporate structure of developing ASCs. This paper proposes two ways to provide such an incentive: (1) an expedited CON and (2) tax breaks. However, as a means of last resort, any legislation should also amend staffing laws to specifically allow hospital boards to control unfair competition by physicians with the use of a controversial practice known as "economic credentialing."

a. Expedited CON for ASCs that are 'Deemed' Compliant

Applying for a CON is considered an expensive and time consuming hassle to some physicians.[469] If the General Assembly wishes to provide additional incentives to include hospitals in the structure of an ASC, the deregulated CON process could allow an expedited CON process for an ASC that includes an accredited tax-exempt hospital in its structure. Any ASC that includes an accredited tax-exempt hospital would be "deemed" to have complied with the sole remaining CON criteria relating to quality and access.

As described above, *supra*, the proposed amended CON process would retain the current quality and access criteria for CON applicants including ASCs. The quality criteria for ASCs include a standard that requires accreditation.[470] Accredited hospitals should already have policies in place that satisfy accreditation standards and should have the experience to conform these policies to the new ASC.[471] In addition, tax-exempt

[469] *See* Bagnato, *supra*, note 352, at 18.
[470] ASC Component Plan, *supra*, note 360, at 14.
[471] *See generally* Joint Commission On The Accreditation Of Healthcare Organizations, The Accreditation Manual For Hospitals (1993) .

hospitals should already satisfy the access criteria due to their tax-exempt status.[472] Therefore, any ASC that include an accredited tax-exempt hospital should already meet the remaining standards relating to quality and access. Allowing for an expedited CON would not only save the entity time and money, but would ease the burden of establishing policies and procedures to meet these criteria.

b. Tax Incentives

Another way to influence physicians to include tax-exempt hospitals in the ASC joint venture is to provide tax incentives to the physicians based on their ownership interest in an ASC that includes a tax-exempt hospital in its corporate structure. Without changing the current tax structure, distributions of profits from the ASC to the physician-owners would be taxed at normal state income tax rates.[473] However, the proposed legislation could include a new state tax rate for taxable income derived from an ASC that includes a tax-exempt hospital as part of its structure. Alternatively, a tax credit could be awarded for those physicians who include hospital in the formation of ASCs. Currently, rural physicians are given a tax credit not to exceed $5,000 for practicing in a rural county.[474] A similar tax credit could be awarded to those physicians who have financial interests in physician-hospital ASCs.

VII. Economic Credentialing

If the above incentives do not influence physicians to include a tax-exempt hospital in a newly developed ASC, tax-exempt hospitals may be forced out of business

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[472] *Compare* Ga. Comp. R. & Reg. r. 111-2-2-.40, *with* I.R.C. § 501(c)(3), *and* 26 CFR 1.501(c)(3)-1, *and* Rev. Rul. 69-145, 1969-2 C.B. 117.
[473] Ga. Code Ann. §48-7-20 (2006) (taxing individual income); Ga. Code Ann. §48-7-21 (2006) (taxing corporate income); Ga. Code Ann. §48-7-23 (2006) (taxing partnership income in the same manner as individual income).
[474] Ga. Code Ann. §48-7-29 (2006).

by the practices of physicians who "cherry-pick" patients for the ASC.[475] 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 hospital boards to utilize economic criteria when making credentialing decisions.

The final portion of this paper will first describe economic credentialing and how it typically is utilized. Next, the paper will discuss how the CON deregulation proposal outlined in this paper 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?

Generally, only those physicians who maintain admitting privileges at a hospital may practice at that hospital.[476] Although the criteria differ from state to state, typically,

[475] *See* Preserving CON, *supra*, note 79, at 13 (citing the economic downfall of Rapid City Regional because of the entry of a competing provider into the market); *But see* MedPAC Report,*supra*, note 2, at 22-24 (concluding that the financial impact of specialty hospitals on competitor hospitals has been limited thus far).

[476] 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.

the criteria are based on training, experience, and clinical competence.[477] This process of review is sometimes referred to as "credentialing."[478] Typically, the duty of credentialing a physician has been the responsibility of the medical staff, subject to approval of the hospital board.[479] Hospital boards usually defer to the medical staff's decision even though they have the ultimate decision making authority.[480] 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.[481] 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.[482] Given the sensitive nature of this subject, however, it is unlikely the decision will be explicitly labeled as made solely on financial criteria.[483] The utilization of financial criteria in the credentialing process is generally referred to as "economic credentialing."[484]

The American Medical Association (hereinafter "AMA") defines economic credentialing as the use of economic criteria unrelated to quality of care or professional

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[477] 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.

[478] 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".

[479] *See* Rice Credentialing Hardball, *supra*, note 476, at 1.

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

[481] *Id.*; Rice Credentialing Hardball, *supra*, note 476, at 1.

[482] *See* Blum, *supra*, note 478, at 182.

[483] *Id.*

[484] *See* Kurs, *supra*, note 477, at 225.

competence in determining a physician's qualifications for initial or continuing hospital medical staff membership or privileges.[485] This definition expresses the AMA's position that financial considerations are not related to quality of care.[486] However, some believe economic credentialing has a quality assurance aspect.[487] 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 the quality of care rendered.[488] A less controversial definition of economic credentialing is the evaluation of a medical staff member based on resource utilization.[489] 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.[490]

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.[491] Opponents claim it is unethical to put hospitals' financial best interests before patient care.[492] Some physicians claim that this practice violates their right to practice medicine and restricts patients' freedom to choose healthcare providers.[493] Opponents also claim that this

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[485] American Medical Association, Policy H-230.975, *available at* http://www.ama-assn.org/apps/pf_new/pf_online.
[486] *See id.*
[487] 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.*
[488] *Id.*
[489] 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.
[490] *See e.g.,* Mahan v. Avera St. Luke's, 2001 S.D. 9, 621 N.W.2d 150 (2001).
[491] *See*, Beverly Cohen, *An Examination of the Right of Hospitals to Engage in Economic Credentialing*, 77 Temp. L. Rev. 705, 710.
[492] Id.
[493] Howard L. Lang, *Economic Credentialing-Why It Must Be Stopped*, 5 Med. Staff Couns. 19, 24 (1991)

power would be abused by hospitals.[494] Also, that it is not permitted under current bylaws (i.e., a practical rather than a theoretical debate).

Proponents claim hospitals use these criteria to maintain the hospital's economic viability.[495] 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.[496] 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.[497] Without these actions, the hospital would be forced out of business, leaving the community with insufficient access to healthcare.[498]

b. How Does Economic Credentialing Work

Traditionally, economic credentialing has appeared as either of, or a combination of, two strategies: closing the staff for a particular specialty or entering into exclusive contracts for that specialty.[499] 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.[500] 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.[501] This may significantly impair the physicians' ability to recruit additional doctors for the specialty hospital.[502]

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[494] *Id.*
[495] Elizabeth A. Weeks, *The New Economic Credentialing: Protecting Hospitals from Competition by Medical Staff Memebers*, 36 J. Health L. 247 (Spring 2003) (hereinafter "Weeks").
[496] *See* Mark Taylor, *Doc Investors in For-Profit Hospitals Denied Staff Privileges*, 32 Mod. Health. 12.
[497] *See id.*
[498] *See id.*
[499] *See* Weeks, *supra*, note 495, at 249-251.
[500] *Id.* at 250.
[501] *See* Mahan, 621 N.W.2d at 152.
[502] *See id.*

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 contracts with other physicians in that specialty.[503] Hospitals claim exclusive contracting produces more efficient operations within the department, thereby increasing quality of care.[504] 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.[505] 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.[506] Further, the contract may require the physician to surrender his other hospital privileges and therefore, maintain admitting privileges solely through the exclusive provider.[507] Therefore, the physician cannot perform procedures at the competing facility without violating his contract with the exclusive provider.[508] Those physicians who do not enter into contracts with the exclusive provider, or to whom the exclusive provider does not extend the opportunity to enter into an employment contract, will effectively not be able to practice at the hospital.[509]

Without privileges, the physician cannot practice.[510] Accrediting standards require that physicians who practice at a hospital must maintain privileges at that

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[503] *See* Weeks, *supra*, note 495, at 249.
[504] *See* Blum, *supra*, note 478, at 181; Mateo-Woodburn v. Fresno Community Hospital, 270 Cal.Rptr. 894, 897-899 (1990).
[505] *See* Weeks, *supra*, note 495, at 249; Mateo-Woodburn, 270 Cal.Rptr. at 897.
[506] Mateo-Woodburn, 270 Cal.Rptr. at 899-900.
[507] *Id.*
[508] *See id.*
[509] *See id.*
[510] Joint Commission On The Accreditation Of Healthcare Organizations, The Accreditation Manual For Hospitals 53 (1993); *See* 42 U.S.C. §§ 1395x(e), 1395bb.

hospital.[511] Hospitals that allow physicians to practice at the hospital without having privileges at the hospital could jeopardize their Medicare and Medicaid provider agreements.[512] Further, managed care providers often require admitting privileges as a prerequisite to becoming a part of their network of physicians.[513] 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. Again, only if maintaining privileges at specific hospital alone isn't enough.

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.[514] Also included in the ASC criteria are standards specific to the intricacies of ASC operations, such as insuring continuity of care.[515] This continuity of care standard requires that each ASC applicant have a medical director who has admitting privileges with a local hospital, and/or the ASC must maintain a hospital

[511] Joint Commission On The Accreditation Of Healthcare Organizations, The Accreditation Manual For Hospitals 53 (1993).
[512] *See* 42 U.S.C. §§ 1395x(e), 1395bb.
[513] Talking Points: Opposing Economic Credentialing, American Medical Association, (November 2005).
[514] Ga. Comp. R. & Reg. r. 111-2-2-.40; ASC Component Plan, *supra*, note 360, at 11-15.
[515] Ga. Comp. R. & Reg. r. 111-2-2-.40(c); ASC Component Plan, *supra*, note 360, at 12.

affiliate agreement or other documented arrangement to ensure the necessary backup for medical complications.[516] The ability to transfer ambulatory patients to hospitals in both emergent and non-emergent situations is critical to ensuring patient safety and care.[517] Further, this transfer arrangement is in keeping with licensure and accrediting standards which, as discussed above 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.[518] 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.[519] Effectively, this means the ASC cannot obtain an ASC CON without a local hospital's cooperation. (This is the point I was trying to make above.)

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.[520] 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.[521] 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".[522] However; if the ASC's permit is revoked, the ASC must cease operations.[523]

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[516] Ga. Comp. R. & Reg. r. 111-2-2-.40(c); ASC Component Plan, *supra*, note 360, at 12.
[517] ASC Component Plan, *supra*, note 360, at 12.
[518] ASC Component Plan, *supra*, note 360, at 12, 14; Joint Commission On The Accreditation Of Healthcare Organizations, The Accreditation Manual For Hospitals (2006).
[519] *See* Ga. Comp. R. & Reg. r. 111-2-2-.40(c); ASC Component Plan, *supra*, note 360, at 12.
[520] Ga. Comp. R. & Reg. r. 290-5-33-.05 (2006).
[521] *See* Ga. Comp. R. & Reg. r. 290-5-33-.05(7); Ga. Comp. R. & Reg. r. 290-5-33-.23 (2006).
[522] 42 U.S.C. § 1395dd.
[523] 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.

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.[524] 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.[525] Other jurisdictions have established precedent that allows hospitals to take this action.[526] 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.[527] While some hospitals have relied on quality and economic concerns when adopting policies relating to exclusive contracting

[524] Ga. Comp. R. & Reg. r. 111-2-2-.40(c).
[525] S*ee, e.g.,* Cobb County-Kennestone Hospital Authority v. Prince, 249 S.E.2d 581 (Ga. 1978).
[526] *See e.g. Mahan,* 621 N.W.2d 150; *Mateo-Woodburn*, 270 Cal.Rptr. 894.
[527] *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).

or closed staffs, at least three courts have upheld a hospital's use of purely economic considerations in denying a physician privileges.[528] Initially, though, the paper will examine a mixed approach found in *Mateo-Woodburn v. Fresno Community Hospital*.[529]

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.[530] 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.[531] 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. [532] Therefore, the hospital board notified its existing medical staff that it was entering into an exclusive contract with a single anesthesia provider.[533] 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.[534] 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.[535] The contracting

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[528] *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).
[529] *See Mateo-Woodburn*, 270 Cal.Rptr. at 896-900.
[530] *See Mateo-Woodburn*, 270 Cal.Rptr. at 896-900.
[531] *Id.* at 896.
[532] *Id.* at 897.
[533] *Id*. at 896.
[534] *Id.* at 899.
[535] *Id*.

physician was required by the employment contract with the exclusive provider to limit his or her professional practice to Fresno Community Hospital.[536]

The California court found that this was a valid exercise of the hospital board's authority.[537] 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."[538] The court also noted that hospitals are under an obligation to remedy any situation which threatens or jeopardizes patient care.[539] Managerial decisions concerning the operation of the hospital are well within the power of the board and will not be overturned unless they clearly appear to be unreasonable, unlawful, or will seriously injure a significant public interest.[540] The hospital may even show bias or prejudice in favor of the selected policy without invalidating the decision.[541] 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.[542]

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 in a less personally directed manner.[543] The court found its situation to be of the latter

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[536] *Id.* at 900.
[537] *Id*. at 905.
[538] *Id.* at 902.
[539] *Id.*
[540] *Id.*
[541] *Id.* at 903.
[542] *Id.* at 902.
[543] *Id.*

variety.[544] Further, the hospital's decision was based mostly on quality of care concerns, although the court classifies the decision as administrative in nature.[545]

The process of pulling the privileges of the ASC medical director, as outlined above, 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.[546] However, there is precedent elsewhere that offers a different perspective.[547]

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.[548] In *Mahan*, local physicians had decided to build a day surgery center that would directly compete with the hospital.[549] The hospital had recently recruited a neurosurgeon that would perform certain spinal procedures similar to those performed at the physicians' surgery center.[550] The board found that a neurosurgeon would not come to the hospital if there were already established orthopedic spine surgeons in the market.[551]

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[544] *Id.*
[545] *Id.* at 897.
[546] *See id.*
[547] *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.
[548] *Mahan*, 621 N.W. 2d at 160.
[549] *Id.* at 153.
[550] *Id.*
[551] *Id.*

During the first seven months that the surgery center was open, the hospital suffered a significant loss of operating room hours.[552] In response to this, the hospital closed its staff to physicians requesting privileges for three spinal procedures, as well as orthopedic surgery.[553] Thereafter, the surgery center physicians recruited a new physician who, in turn, requested privileges at the hospital.[554] The hospital denied his requests and he brought suit claiming that the action was in breach of the medical bylaws.[555]

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.[556] The decision by the board was a decision on how to operate a department within the corporation.[557] 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.[558]

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.[559] 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.[560] These decisions must be protected to ensure that

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[552] *Id.*
[553] *Id.*
[554] *Id.*
[555] *Id.*
[556] *Id.* at 156.
[557] *Id.*
[558] *Id.*
[559] *Id.* at 160.
[560] *Id.*

the hospital is able to provide care for the community.[561] The hospital determined that it was in the best interests of the community to provide 24-hour neurosurgical services.[562] In order to provide that coverage the hospital needed to recruit neurosurgeons.[563] To recruit the required physicians, the board determined that the staff needed to be closed.[564] The court found that this decision was economically reasonable.[565]

Therefore, the action by the board to close the staff was a reasonable administrative decision compliant with the by-laws.[566] 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.[567] South Dakota, however, is not alone in this holding.[568] But this decision was aimed at a category of providers, not a single medical director.

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 effect of the decision is a valid exercise.[569] In *Lister*, the physician was an anesthesiologist with privileges at the hospital.[570] The hospital subsequently entered into an exclusive contract for the provision of anesthesia with a group that did not include the plaintiff physician.[571] The physician sued, claiming

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[561] *Id.*
[562] *Id.* at 158.
[563] *Id.*
[564] *Id.*
[565] *Id.*
[566] *Id.* at 160.
[567] *Id.*
[568] *See Lister*, 1993 Tenn. App. LEXIS 717, *2; *Rosenblum*, No. 91-589.
[569] *Lister*, 1993 Tenn. App. LEXIS 717, *2.
[570] *Id.*
[571] *Id.*

breach of contract.[572] 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.[573]

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.[574] The by-laws did not make competency and conduct the exclusive basis for terminating privileges.[575] Moreover, the court recognized that hospital staffing decisions involving specialized medical and business considerations are entitled to deference from the courts.[576] 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.[577] The Court of Appeals of Florida has recently taken a similar approach.[578]

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.[579] The plaintiff had been a member of the medical staff and had clinical privileges in anesthetic and pain management since 1995.[580] His privileges expired in 1997 and were not renewed by the

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[572] *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).
[573] *Lister*, 1993 Tenn. App. LEXIS 717, *2.
[574] *Id.* at *5.
[575] *Id.*
[576] *Id.* at *3 (citing *Lewisburg*, 805 S.W. 2d 756).
[577] *Id.* at *5.
[578] *See* Naples Community Hospital v. Hussey, 918 So. 2d 323 (Fla. Dist. Ct. App. 2005).
[579] *Id.* at 324.
[580] *Id.*

hospital.[581] Instead, the hospital entered into an exclusive contract for the provision of anesthetic and pain management services.[582] The physician sued, claiming breach of contract.[583]

The court recognized that Florida has adopted the majority view that hospital by-laws are a binding and enforceable contract between the hospital and the medical staff when approved by the governing board of the hospital.[584] Therefore, the court looked to the bylaws to determine whether the hospital had breached any contractual duty owed to the physician.[585] The bylaws 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 assessment activities, peer recommendations concerning skills, and board certification status.[586]

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.[587] 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

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[581] *Id.*
[582] *Id.*
[583] *Id.*
[584] *Id.* at 325.
[585] *See id.*
[586] *Id.* at 326.
[587] *Id.*

enter into an exclusive contract, and not because of recommendations from department chairpersons.[588] The doctor's competence had not been called into question and his or her reputation was not at stake.[589] The court held that the hearing process described in the by-laws clearly did not apply to this situation.[590] 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.[591]

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.[592] Therefore, the courts arguably were merely construing contracts and were not focused on solely the hospitals' actions.[593] However, not every state recognizes that hospital by-laws create contract rights for physicians.[594] 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

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[588] *Id*.
[589] *Id.*
[590] *Id.* at 327.
[591] *See id.*
[592] *Compare id.* at 324, *with Lister*, 1993 Tenn. App. LEXIS 717, *2, *and Mahan*, 621 N.W. 2d at 156.
[593] *Compare id.* at 324, *with Lister*, 1993 Tenn. App. LEXIS 717, *2, *and Mahan*, 621 N.W. 2d at 156.
[594] *See, e.g.,* Stein v. Tri-City Hospital, 384 S.E.2d 430, 432-433 (Ga. Ct. App. 1989).

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.[595] 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 exercise of the inherent police power of the sovereign.[596] 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.[597] Each party exercises rights exclusive of the other, although each has areas of responsibility in the treatment and diagnosis of patients.[598] One such area for hospitals is the responsibility to render decisions in regards to the administration, operation, maintenance and control of the hospital.[599] 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.[600] Hospitals meet this obligation, in part, by properly credentialing their physicians.[601] Traditionally, Georgia courts have shown deference to both public

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[595] *Cobb County-Kennestone*, 249 S.E.2d 581.
[596] *Id*.
[597] *Id*. at 584.
[598] *Id*.
[599] *See id.* at 585-586.
[600] 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).
[601] *See Cobb County-Kennestone*, 249 S.E.2d at 585.

and private hospital boards when administrative decisions affecting a physician's privileges have been questioned.[602]

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.[603] Moreover, a public hospital authority has the ultimate power to manage and operate the hospital.[604]

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.[605] 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.).[606] The physicians proposed that they be allowed to lease space at the hospital in order to operate

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[602] *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).
[603] Ga. Code Ann. §31-7-7 (2006).
[604] Ga. Code Ann. §31-7-75 (2006).
[605] *Cobb County-Kennestone*, 249 S.E.2d at 588.
[606] *Id*. at 582-583.

the machine.[607] The authority rejected the proposal, citing a policy against leasing space at the hospital to for profit enterprises, but indicated that the hospital would consider providing these services if the need was apparent.[608] 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.[609] The physicians rejected the counter-proposal and instead began negotiations to purchase the machine and locate it outside of the hospital complex.[610]

The hospital sought and was granted approval for the purchase of a C.A.T. machine.[611] The hospital then issued a memorandum to all medical staff members announcing its intent to purchase the machine.[612] Thereafter, the five physicians finalized negotiations for the purchase of their machine.[613] 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."[614] 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

[607] *Id*. at 583.
[608] *Id*.
[609] *Id*.
[610] *Id*.
[611] *Id*.
[612] *Id*.
[613] *Id*.
[614] *Id*.

continuation of the hospital's ability to provide proper service and facilities.[615] Because the physicians' machine was operable first, in-patients were initially allowed to be transported to the off-site scanner.[616] However, when the hospital's scanner became operational, this practice was stopped.[617]

Thereafter, the physicians continued to refer patients to their off-site facility.[618] 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.[619] 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.[620]

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.[621] Although this was an issue of first impression, the court found persuasive that other jurisdictions had upheld a hospital's decision requiring in-patients to receive services from one physician or group of physicians to the exclusion of other medical-staff members.[622] Practical considerations of

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[615] *Id*. at 584.
[616] *Id*. at 583-584.
[617] *Id*. at 584.
[618] *Id*.
[619] *Id*.
[620] *Id*.
[621] *Id*. at 585-586.
[622] *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

hospital operation permit hospital administrators to conclude that specialty services can best be provided by entering into exclusive medical service contracts.[623] 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.[624] Therefore, the court found the hospital's resolution to be a reasonable and rational administrative decision.[625]

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 it may meet its duty to provide healthcare services to the general public.[626] This power is an intricate part of a public hospital's ability to provide healthcare in the community.[627] However, Georgia courts have not limited the power derived from the public hospital staffing statutes to public hospitals.[628]

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*.[629] 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

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an x-ray machine was not arbitrary or unreasonable and was an administrative action in furtherance of the operation and control of the hospital)).
[623] *Id*. at 147 (citing Radiology Professional Corp. v Trinidad Area Health Asc., Inc., 195 Colo. 25, 577 P.2d 748 (1978).
[624] *Id*. at 588.
[625] *Id*.
[626] *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).
[627] *See id.*
[628] *See St. Mary's*, 421 S.E.2d 731.
[629] *Id.*

practice and that such authority included the concomitant right to terminate staff privileges to maintain this exclusivity.[630] St. Mary's granted Dr. Cohen privileges in the 1960's.[631] In 1971, the hospital entered into an exclusive contract for radiological services with Radiology Professional Corporation (hereinafter R.P.C.) owned by Dr. Cohen.[632] The contract provided that either party could terminate the contract without cause upon giving the requisite notice to the other party.[633] This litigation arose when St. Mary's attempted to terminate its contract with the R.P.C and terminate Dr. Cohen's privileges.[634]

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.[635] 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.[636] 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.[637]

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.[638] Although it seems clear that hospitals can enter into exclusive

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[630] *Id*. at 737.
[631] *Id*. at 733.
[632] *Id*.
[633] *Id*.
[634] *Id*. at 734.
[635] *Id*
[636] *Id*.
[637] *Id*. at 737.
[638] *See id.* at 731; *Cobb County-Kennestone*, 249 S.E.2d at 585.

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.[639] Further, they should be afforded notice and a hearing before the hospital authority and not just the medical staff.[640] 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.[641]

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.[642] Dr. Cohen argued that terminating his medical staff privileges

[639] Shaw v. Hospital Authority of Cobb County, 507 F.2d 625, 628 (5th Cir.) (1975).
[640] *Id*.
[641] *See St. Mary's*, 421 S.E.2d at 735-737.
[642] *St. Mary's*, 421 S.E.2d at 737.

was a tortious denial of due process rights contractually guaranteed.[643] 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.[644]

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.[645] 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.[646]

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.[647] 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.[648] Basically, the claim must be supported by some state statute, legal rule, or a mutually explicit understanding.[649] 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

[643] *Id*. at 735.
[644] *Id*.
[645] *Id*. at 735-736.
[646] *Id*. at 736.
[647] *See* Todorov v. DCH Healthcare Authority, 921 F.2d 1438, 1462 (11th Cir. 1991).
[648] *Id.*
[649] *Id.* at 1463 (citing Perry v. Sindermann, 408 U.S. 593, 601-602 (1972)).

without the requested privileges.[650] For those providers with exclusive contracts, this is an easy analysis.[651] Otherwise, the court must analyze the effect of the decision on the physician's ability to maintain his/her practice.[652]

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.[653] 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.[654] Therefore, due process must be given.[655]

The extent of the due process depends on the situation.[656] 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.[657] 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.[658]

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

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[650] *Id.* (citing Shahawy v. Harrison, 778 F.2d 636, 642 (11th Cir.1985)).
[651] *See* Northeast Georgia Radiological Asc. V. Tidwell, 670 F.2d 507, 511 (M.D. Ga. 1982).
[652] *See Todorov*, 921 F.2d at 1464.
[653] *Todorov*, 921 F.2d at 1464 (citing Burkette v. Lutheran Gen. Hosp., 595 F.2d 255, 256 (5th Cir.1979)).
[654] *Burkette*, 595 F.2d at 256.
[655] *See id.*; *Todorov*, 921 F.2d at 1464; *Shahawy*, 778 F.2d at 642.
[656] *See* Bellam v. Clayton County Hospital Authority, 758 F.Supp. 1488, 1492 (N.D. Ga. 1990).
[657] *Bellam*, 758 F.Supp. at 1492.
[658] *Shaw*, 507 F.2d at 627.

regulations governing the appointment of physicians to the hospital staff.[659] Medical staff bylaws alone do not create any contractual right to continuation of staff privileges in Georgia.[660] 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.[661] 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.[662] The court inferred, however, that the decision may have been different if Dr. Cohen had an additional 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.[663]

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 in tort if Dr. Cohen's staff privileges were terminated without complying with the provisions of the staff bylaws concerning notice and a hearing.[664] 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.[665]

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

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[659] *St. Mary's*, 421 S.E.2d at 736 .
[660] *Id*.
[661] *Id.*
[662] *Id*.
[663] *Id*.
[664] *Id*. at 736-737.
[665] Ga. Stat. Ann. § 51-1-6 (2006).

complies with applicable laws, rules, and regulations.[666] Such privileges may not be deprived by rules or acts that are unreasonable, arbitrary, capricious, or discriminatory.[667] 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.[668] While the hospital has broad authority to change the bylaws, it cannot refuse to follow existing bylaws.[669] Doing so is a violation of a legal duty, and therefore is actionable under section 51-1-6.[670]

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.[671] This is true for public as well as private hospitals.[672] Accordingly, Dr. Cohen, as a member of the medical staff, should have been afforded the due process protections provided for in the staff bylaws.[673] 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 physician.[674] 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.[675]

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

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[666] *St.Mary's*, 421 S.E.2d at 736.
[667] *Id*.
[668] *Id*. at 737.
[669] *Id*.
[670] *Id*.; *See* Ga. Stat. Ann. § 51-1-6.
[671] *St.Mary's*, 421 S.E.2d at 737.
[672] *Id*.
[673] *Id*.
[674] *Id*.
[675] *Id*.

privileges.[676] Further, the right to revoke a physician's privileges for economic reasons must be outlined in the bylaws.[677] 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.[678] This detailed process was reiterated in a more recent Georgia case.[679]

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.[680] This case involved a private non-profit hospital attempting to change from one exclusive provider of cardiovascular services, SGCA, to another.[681] Prior to entering into the exclusive contract with SGCA, the doctors comprising SGCA were on the medical staff of the hospital.[682] The doctors maintained their privileges throughout the exclusive contract period.[683]

Thereafter, the hospital terminated the contract and entered into a contract with another cardiovascular group, Baptist Specialty.[684] The hospital notified the SGCA physicians that their privileges were terminated because of the termination of the contract.[685] The SGCA physicians sought an injunction prohibiting the hospital from limiting their practice at the hospital.[686] The hospital then adopted a resolution providing that only those physicians employed by or under contract with Baptist Specialty would be

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[676] *See id.*
[677] *See id.*
[678] *See id.*
[679] Satilla Health Services v. Bell, 633 S.E.2d 575 (Ga. Ct. App. 2006).
[680] *Id.*
[681] *Id*. at 125.
[682] *Id*.
[683] *Id*.
[684] *Id*.
[685] *Id*.
[686] *Id*.

entitled to use the facilities for cardiology privileges as long as the exclusive contract was in effect.[687] It also provided that the action taken did not constitute a revocation or termination of privileges of the affected physicians.[688]

The hospital was apparently attempting the same strategy found in *Mateo-Woodburn*, discussed above.[689] The Georgia Court found that the hospital had the authority to terminate the SGCA contract and enter into an exclusive contract with Baptist Specialty. However, contrary to the California court finding in *Mateo-Woodburn*, the court held that by denying the physicians access to the hospital facilities, the hospital was effectively terminating their privileges.[690] Therefore, as discussed above, the hospital must have 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*.[691] 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.[692]

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.

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[687] *Id*. at 126.
[688] *Id*.
[689] *See Mateo-Woodburn*, 270 Cal.Rptr. at 894 (1990).
[690] *Satilla*, 280 Ga. App. at 131.
[691] *Id*.
[692] *Id*.

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.[693] 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.[694] 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.[695] 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.[696]

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.[697] Preserving the efficient operation of a hospital department is an example of one such explanation.[698] 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.[699]

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[693] 15 U.S.C. § 1 (2006).
[694] Fisher v. City of Berkeley, 475 U.S. 260, 266 (1986).
[695] *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).
[696] *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).
[697] *Torodov*, 921 F.2d at 1456.
[698] *Id.*
[699] *Id.* at 1459.

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.[700] Section 2 imposes liability on both concerted and unilateral acts.[701]

i. State Action Immunity

Under the state action immunity doctrine, states are immune from federal antitrust law for their actions as sovereign.[702] A municipality is entitled to state action immunity if it acted pursuant to clearly articulated and affirmatively expressed state policy.[703] 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.[704] However, the analysis is not the same for private hospitals.[705]

Private parties can claim state-action immunity from Sherman Act liability only when their anticompetitive acts were truly the product of state regulation.[706] 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.[707] First, the challenged restraint must be one clearly articulated

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[700] 15 U.S.C. § 2 (2006).
[701] See, e.g., Copperweld Corp. v. Independence Tube Corp., 467 U.S. 752 (1984).
[702] 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).
[703] Town of Hallie v. City of Eau Claire, 471 U.S. 34, 46-47, 105 (1985).
[704] *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).
[705] *See* Patrick v. Burget, 486 U.S. 94, 99-102 (1988).
[706] *Id.* at 100.
[707] *See* California Retail Liquor Dealers Assn. v. Midcal Aluminum, Inc., 445 U.S. 97, 105 (1980).

and affirmatively expressed as state policy.[708] Second, the anticompetitive conduct "must be actively supervised by the State itself.[709]

The first prong maybe satisfied by an expression of such in a statute.[710] 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."[711] 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.[712] Georgia's staffing statute is specifically aimed at public hospitals and there is no corresponding statute for private hospitals.[713] 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).[714] Those participating in professional review actions are immunized from damages.[715] 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

[708] *Id.* at 105 (citing Lafayette v. Louisiana Power & Light Co., 435 U.S. 389, 410 (1978)).
[709] *Id.*
[710] *Hallie*, 471 U.S. at 40-42.
[711] *Patrick*, 486 U.S. 94 .
[712] *Id.*
[713] Ga. Code Ann. § 31-7-7.
[714] *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).
[715] 42 U.S.C. § 11111(a)(1).

provided to the physician; and (4) the action was warranted by the facts.[716] However, a 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.[717] 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.[718]

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.[719] The AMA argues that exclusive contracting based on economic criteria violates the federal anti-kickback statute.[720] The Office of the Inspector General

[716] 42 U.S.C. § 11112(a)(1-4).
[717] Wood v. Archbold Memorial Medical Ctr., 2006 U.S. Dist. LEXIS 44292, *8-9 (June 29, 2006).
[718] *Id.* at *5 (citing Kirby v. Siegelman, 195 F.3d 1285, 1289 (11th Cir. 1999)).
[719] 42 U.S.C. § 1320a-7b (b).
[720] 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.

(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.[721]

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.[722] 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.[723] 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.[724]

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.[725] However, the possibility of civil money penalties from the OIG and possible exclusion from federal healthcare programs maybe even more discouraging.[726] 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

[721] 70 FR 4858, 4869 (2005).
[722] *Id*.
[723] *Id.*
[724] *Id*.
[725] 42 U.S.C. § 1320a-7b (b).
[726] *See* 42 U.S.C. § 1320a-7a (2006); 42 U.S.C. § 1320a-7 (2006).

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.[727] Indeed, it could be argued that the General Assembly has already expressed this intent into the public hospital statute.[728] 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.[729] 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 above, Georgia courts have held that this phrase evidences the legislature's intent to give hospital boards power to become involved in anticompetitive conduct.[730] Further, this language mirrors that in the North Carolina staffing law that courts have held conferred anticompetitive power.[731] 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

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[727] *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).
[728] *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")).
[729] Ga. Code Ann. §31-7-7 (2006).
[730] *Sweeney v. Athens Regional Medical Center*, 705 F.Supp. 1556, 1563 (M.D. Ga. 1989).
[731] *Coastal Neuro-Psychiatric*, 795 F.2d at 342.

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 apply to private hospitals and include a more expansive definition of what constitutes "reasonable objectives" or "the appropriate utilization of hospital facilities", this would lessen the chance of litigation in regards to adverse credentialing actions. The expansive definition could include language that would make it more palatable under fraud and abuse laws, for example by stating that "reasonable objectives" includes thwarting significant conflicts of interest.

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 decisions.[732]

[732] *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).

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 will not utilize improper patient selection techniques. Overall, this proposal would bring about greater competition while enhancing quality, access, and convenience for patients.