

**CONFLICTS CREDENTIALING: HOSPITALS AND THE  
USE OF FINANCIAL CONSIDERATIONS TO MAKE  
MEDICAL STAFFING DECISIONS**

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As reimbursement rates decline or remain stagnant, an increasing number of physicians are acquiring ownership interests in freestanding health care facilities, such as ambulatory surgical centers (ASCs), sleep disorder centers, and single-specialty hospitals, including long-term acute care and rehabilitation hospitals. These outpatient, freestanding facilities provide a means for physicians to increase their earnings by sharing in the profits of health care while also directly controlling the quality of care delivered to their patients. Among other things, ownership and joint ventures enable physicians to bill both for the professional component and facility fee component of services rendered,

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increasing physician revenue opportunities.

The relationship between a hospital and its medical staff is symbiotic. Physicians and hospitals have struggled to provide services as the cost of providing health care has soared, reimbursement has decreased, and health care is delivered in a highly regulated environment. As physicians increasingly invest in freestanding outpatient facilities, hospitals are questioning the impact of this competition upon hospital revenue and the patient base.

The growth in specialty hospitals and other freestanding facilities has been controversial. In October 2003, the United States General Accounting Office (GAO) issued a report to Congress entitled "Specialty Hospitals: Geographic Location, Services Provided, and Financial Performance."<sup>1</sup> In this report, the GAO found that seventy percent of the specialty hospitals it reviewed had some degree of physician ownership.<sup>2</sup> The GAO noted that "21 out of 25 specialty hospitals treated a lower percentage of patients who were severely ill compared with patients in the same diagnosis categories treated at general hospitals in the same urban areas."<sup>3</sup> The report also concluded that specialty hospitals treated a smaller percentage of Medicaid patients than general hospitals.<sup>4</sup> These patients account for some of the lowest levels of reimbursement.

Physician investment in specialty hospitals and other freestanding healthcare providers has led many tertiary hospitals to claim that the physicians owning freestanding healthcare facilities are "cherry picking" the patients with less severe medical problems and better insurance coverage, leaving the hospitals to contend with the sicker patients with higher acuties who have Medicaid or are uninsured.<sup>5</sup> Not-for-profit and community hospitals usually do not have the ability or desire to turn away patients based upon ability to pay. Hospitals argue that physicians who invest in freestanding facilities are diverting from the hospitals certain procedures with higher reimbursement rates and lower costs,

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1. GAO-04-167 (Oct., 2003), *available at* <http://www.gao.gov/new.items/d04167.pdf>.

2. *Id.* at 9.

3. *Id.* at 7-8.

4. *Id.* at 4.

5. FED. TRADE COMM'N & DEP'T OF JUSTICE, IMPROVING HEALTH CARE: A DOSE OF COMPETITION, 20-21 (July 2004), *available at* <http://www.ftc.gov/reports/healthcare/040723healthcarept.pdf>.

which in turn affects the ability of the hospitals to provide emergency care and other essential services needed by the local community.<sup>6</sup>

The response by hospitals to the growth of ASCs and single-specialty hospitals has been multi-fold. With hospital industry backing, Congress included in last year's Medicare Prescription Drug legislation an eighteen month moratorium prohibiting a physician from referring a patient to cardiac, orthopedic, or surgical specialty hospitals in which the physician had an ownership or investment interest.<sup>7</sup> Hospitals have initiated or participated in mutually beneficial partnerships or joint ventures with physicians, within the limits set by the fraud and abuse regulations and the restrictions imposed on tax-exempt institutions, to encourage physicians to invest with the hospital instead of with potentially competing freestanding facilities.<sup>8</sup> Hospitals have also used their market power to enter into exclusive contracts with payors to freeze out specialty hospitals and/or ASCs from provider lists.<sup>9</sup>

Hospitals have also responded to this perceived economic threat by injecting economic factors into the credentialing process and the grant of medical staff privileges to physicians.<sup>10</sup> These hospitals are electing to impose penalties, including the loss of medical staff privileges, upon physicians whose conduct is deemed by the hospital administrators and governing bodies to be disloyal or otherwise in conflict with the economic interests of the hospitals.<sup>11</sup>

Such "conflicts credentialing" occurs when a hospital considers a physician's relationship with other hospitals or freestanding entities that compete with the hospital to which the physician is seeking or maintaining medical staff privileges.<sup>12</sup> Through conflicts

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6. *Id.* at 21-22.

7. Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, § 507, 117 Stat. 2066, 2295-97.

8. HEALTH LAW PRACTICE GUIDE § 32:2 (West, 2004).

9. *See, e.g.*, Rome Ambulatory Surgical Ctr., LLC v. Rome Mem'l Hosp., No. 5:01-CV-23, at 4-5 (N.D.N.Y. Dec. 22, 2004); *supra* note 5, at 23.

10. *See, e.g.*, AM. MED. ASSOC., ORGANIZED MED. STAFF SECTION, ECONOMIC CREDENTIALING, available at <http://www.ama-assn.org/ama/bup/category/10303.html> (last visited Feb. 8, 2005); Judith E. Orié, Comment, *Economic Credentialing: BottomLine Medical Care*, 36 DUQ. L. REV. 437, 437-38 (1998).

11. *See infra* Part II (discussing cases where hospitals have attempted to deny or rescind staff privileges based on economic or conflict criteria).

12. Robert J. Milligan & Michelle Notrica, *Plata o Plomo: Hospital Medical Staff Relations in the Era of Conflicts Credentialing*, 2 HEALTH LAWYERS WEEKLY 35, Sept. 3,

credentialing, hospitals seek to deny, rescind, or hinder the staff privileges of physicians who invest in freestanding facilities that hospitals perceive as competing for patients and revenues in the relevant health care market.

The emerging practice of conflicts credentialing represents a significant change in the economic and professional interests of physicians and in the relationship between medical staffs and hospitals. In this article, the authors explain the interrelationship between the authority of hospitals and medical staffs to manage their respective affairs and the legal developments that have led toward conflicts credentialing.<sup>13</sup> The authors next discuss the medical community's reaction to conflicts credentialing and the legal challenges facing the use of economic factors in physician credentialing.<sup>14</sup>

#### I. MEDICAL STAFF CREDENTIALING

Hospital medical staff privileges were typically granted to physicians who were able to provide quality patient care and meet all of the requisite education and licensure requirements. The traditional perception was that training, experience, and general practice were of primary importance in the credentialing process, and hospital staff privileges were granted to physicians who provided quality patient care.<sup>15</sup> Credentialing decisions were historically based on quality considerations and a determination of the applicant physician's current clinical competence, for example, appropriate medical training, unrestricted state licensure, medical liability coverage, and an unrestricted federal DEA number.<sup>16</sup> The physician requesting privileges demonstrated the appropriate education, training, experience, and expertise to exercise those privileges.<sup>17</sup>

In addition, physicians have maintained memberships on multiple medical staffs to (1) treat patients at the facility offering the best care and (2) accommodate cross coverage of patients.<sup>18</sup>

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2004, available at <http://www.healthlawyers.org/hlw/issues/040903/print.cfm>.

13. See *infra* Part I.

14. See *infra* Part III-IV.

15. See Letter from Ratcliffe Anderson, Jr., American Medical Association, to Ms. June Gibbs Brown, Office of Inspector General, Department of Health and Human Services (Dec. 2, 1999) (on file with author).

16. *Id.*

17. *Id.*

18. *Id.*

Hospitals have also been traditionally open to permitting qualified local physicians to enjoy medical staff privileges at other hospitals; tax exempt hospitals are generally required to maintain an “open medical staff.”<sup>19</sup>

Medical staff credentialing is governed by state laws,<sup>20</sup> the Medicare Conditions of Participation,<sup>21</sup> and the accreditation standards implemented by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).<sup>22</sup> When hospitals, through their medical staffs, utilize this approach, economic considerations do not factor into the hospital’s credentialing process and decisions. Physicians who are members of a hospital’s medical staff usually are required by the hospital’s medical staff rules and regulations, as a condition of their continued medical staff membership, to serve on various hospital committees which may include credentialing, bylaws, and institutional review board committees that perform peer review and act primarily for the benefit of the hospital.<sup>23</sup>

The use of economic criteria by the hospital as part of the credentialing process is a break from this traditional view and reflects the financial pressures now facing both hospitals and physicians. With economic credentialing, the hospital, either directly or by amending the medical staff bylaws to include a “conflicts policy,” interjects economic criteria into the decision to grant or permit a physician to maintain staff privileges.<sup>24</sup> The hospital provides the physician with a conflict of interest statement or other questionnaires addressing the nature of the physician’s relationship with other hospitals or health care entities.<sup>25</sup> This

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19. *Id.*

20. *Id.* For example, Illinois law states that “all hospitals licensed under this Act (Illinois Hospital Licensing Act), except county hospitals as defined in subsection (c) of Section 15-1 of the Illinois Public Aid Code, shall comply with, and the medical staff bylaws of these hospitals shall include rules consistent with, the provisions of this Section in granting, limiting, renewing, or denying medical staff membership and clinical staff privileges.” 210 ILL. COMP. STAT. 85/10.4(b) (2004).

21. 42 C.F.R. § 482.12(a)(5) (2005).

22. Joint Commission on Accreditation of Healthcare Organizations Standards (JCAHO), MS 4.10-4.40 (2004), at <http://www.jcaho.org/htba/hospitals/facts.htm>.

23. *Id.*

24. American Medical Association, *Economic Credentialing*, (explaining the American Medical Association Policy H-230.975), at <http://www.ama-assn.org/ama/pub/category/10303.html> (last visited February 8, 2005).

25. See, e.g., Complaint ¶5, *Murphy v. Baptist Health*, (13th Div. Civ. Ct. Ark.

inquiry by the hospital may occur as part of the credentialing process at the time the physician applies or reapplies for privileges, or at any time that the physician is a member of the hospital's medical staff.<sup>26</sup>

The hospital's governing body reviews the physician's responses to the hospital's written questions to determine if the physician has a financial interest in a health care facility that conflicts with the hospital.<sup>27</sup> If a perceived financial conflict exists, the hospital may deny the physician medical staff privileges or remove the physician from the hospital's medical staff if the physician is an active medical staff member.<sup>28</sup> Appeal rights are often curtailed or non-existent.<sup>29</sup>

## II. THE EMERGING TREND FROM MEDICAL QUALIFICATIONS TO ECONOMIC AND CONFLICTS CREDENTIALING

The advent of exclusive provider contracts between hospitals and physicians signaled a departure from the use of medical criteria to determine a physician's clinical competence and certification for staff privileges. Exclusive provider contracts arise when a hospital contracts with an outside physician or physician group to exclusively use certain hospital facilities, such as radiology or emergency room units. Physicians who are not parties to the exclusive provider contracts are denied privileges or their existing privileges are limited or revoked to perform the medical services that are being exclusively performed by physicians or the group practice that entered into these contracts.

Physicians who were adversely affected by such contracts, and denied or excluded from medical staff privileges as a result, challenged the exclusive agreements as unreasonable restraints of trade and on other theories. In most states, the courts found that granting exclusive contracts was a legitimate exercise of a hospital's inherent right to conduct its independent business affairs and that staff medical privileges were not an entitlement.<sup>30</sup> Many courts, as

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filed Feb. 24, 2004) (No. CV2004-2002).

26. *See, e.g.*, Second Amended Complaint ¶ 82, *Med. Staff of Cmty. Mem'l Hosp. of San Buenaventura v. Cmty. Mem'l Hosp. of San Buenaventura* (Cal. Super. Ct. 2003) (No. CIV 219107).

27. *Id.*

28. American Medical Association, *supra* note 24.

29. *See* Complaint ¶ 7, *Murphy* (No. CV2004-2002).

30. *See* *Howerton v. Grace Hosp., Inc.*, No. 95-2549, 1996 WL 498095, at \*1 (4th Cir. N.C. Sept. 4, 1996) (*per curiam*); *Drs. Steuer & Latham, P.A. v. Nat'l*

well as the Federal Trade Commission, have concluded that exclusive contracts foster competition and enhance the delivery of health care, outweighing the anti-competitive and exclusionary aspects of the contracts on physicians who were denied staff privileges.<sup>31</sup>

There is no uniform definition of economic credentialing. The American Medical Association (AMA) defines economic credentialing as “the use of economic criteria unrelated to quality of care or professional competence in determining a physician’s qualifications for initial or continuing hospital medical staff membership or privileges.”<sup>32</sup> The term embodies a complete and diverse set of practices that affect the staffing privileges of physicians on economic grounds. As one expert explained:

Increasingly, physicians are evaluated on criteria such as: number of patients treated, time allotted to each patient, amount of insurance reimbursement received, number of referrals and consultations, medication costs, liability claims, patient satisfaction surveys, and other similar economic factors. The terms “economic efficiency” and “cost containment,” frequently touted by hospitals, are merely euphemisms for economic credentialing.<sup>33</sup>

The term “conflicts credentialing” is a new and more targeted form of economic credentialing. It is not to be confused with a “conflicts of interest” which precludes a partner or a corporate officer from competing with the partnership or corporation. Absent express medical staff bylaws to the contrary, physicians are not agents of the hospital and hospitals generally resist the suggestion or argument that physicians are agents of the hospital.<sup>34</sup> Rather, the concept of conflicts credentialing rests with those cases

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Med. Enter., No. 87-3753, 1988 WL 46286, at \*1 (4th Cir. May 10, 1988) (per curiam); Redding v. St. Francis Med. Ctr., 255 Cal. Rptr. 806 (Cal. Ct. App. 1989); Garibaldi v. Applebaum, 742 N.E.2d 279 (Ill. 2001); Dutta v. St. Francis Reg’l Med. Ctr., 867 P.2d 1057 (Kan. 1994); Bartley v. E. Maine Med. Ctr., 617 A.2d 1020 (Me. 1992) (holding notice and hearing provisions not triggered by policy requiring exclusive contracts); Vakil v. Anesthesiology Assoc. of Taunton, 744 N.E.2d 651 (Mass. App. Ct. 2001); Van Valkenburg v. Paracelsus Healthcare Corp., 606 N.W.2d 908 (N.D. 2000); Tenent Health Ltd. v. Zamora, 13 S.W.3d 464 (Tex. Ct. App. 2000).

31. *In re Burnham Hosp.*, 101 FED. TRADE COMMISSION 991 (1983).

32. American Medical Association, *supra* note 24.

33. Judith E. Orie, M.D., *Economic Credentialing: Bottom Line Medical Care*, 36 DUQ. L. REV. 437, 437-38 (1998).

34. *See Haven v. Randolph*, 342 F. Supp. 538, 542 (D.D.C. 1972); *Espalin v. Children’s Med. Ctr. of Dallas*, 27 S.W.3d 675, 683-84 (Tex. Ct. App. 2000).

recognizing the right of a hospital's board to exercise its business judgment to run the business affairs of the hospital.

*Mahan v. Avera St. Luke's*<sup>35</sup> is one of the leading cases on the topic of conflicts credentialing. In that case, the South Dakota Supreme Court recognized the right of the hospital to use economic criteria and potential conflicts to make credentialing decisions without looking at a physician's medical credentials or abilities.<sup>36</sup>

Avera St. Lukes (ASL) was a private, nonprofit hospital in Aberdeen, South Dakota.<sup>37</sup> A group of orthopedic surgeons formed Orthopedic Surgery Specialists (OSS) and built a day surgery center to compete with ASL.<sup>38</sup> In the first seven months of OSS operation, "ASL suffered a 1000 hour loss of operating room usage."<sup>39</sup>

In response, ASL's Board of Trustees (the Board) passed two resolutions: one "clos[ing] ASL's medical staff with respect to physicians requesting privileges" to perform certain spinal procedures and the second "clos[ing] the medical staff to applicants for orthopedic privileges except for two general orthopedic surgeons being recruited by ASL."<sup>40</sup> In passing these resolutions, the Board "specifically determined that the staff closures were in the best interests of the Aberdeen community and the surrounding area."<sup>41</sup> The closure did not affect the physicians who had already been granted staff privileges.<sup>42</sup>

Mahan was an orthopedic surgeon recruited by OSS.<sup>43</sup> Mahan applied for staff privileges at ASL after he began practicing at OSS.<sup>44</sup> ASL denied Mahan's request for privileges; subsequently OSS and Mahan brought suit for breach of the medical staff bylaws.<sup>45</sup>

The trial court reasoned that "the Board had delegated . . . authority concerning staff privileges to the medical staff," and therefore "no longer had the power to initiate actions that affected

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35. 2001 SD 9, 621 N.W. 2d 150 (S.D. 2001).

36. *Id.* ¶ 32, 621 N.W.2d at 160.

37. *Id.* ¶ 2, 621 N.W.2d at 152.

38. *Id.* ¶ 5, 621 N.W.2d at 153.

39. *Id.*

40. *Id.* ¶ 6, 621 N.W.2d at 153.

41. *Id.*

42. *Id.*

43. *Id.* ¶ 7, 621 N.W.2d at 153.

44. *Id.*

45. *Id.* ¶¶ 7-8, 621 N.W.2d at 153.

the privileges of the medical staff.”<sup>46</sup> The trial court found that “the Board had breached its contract with the medical staff” when it unilaterally closed staff privileges.<sup>47</sup> The South Dakota Supreme Court reversed.<sup>48</sup>

The South Dakota Supreme Court reaffirmed that the bylaws were an enforceable contract between the hospital and physicians,<sup>49</sup> but disagreed with the trial court’s determination of the language and effect of that contract.<sup>50</sup> The court reasoned that pursuant to South Dakota law, “the affairs of a [non-profit] corporation *shall* be managed by a board of directors,”<sup>51</sup> and that a hospital was required to “have ‘a medical staff organized under bylaws and rules approved by the governing body and *responsible to the governing body of the hospital* for the quality of all medical care provided patients in the hospital and for the ethical and professional practices of its members.”<sup>52</sup> “[D]irectors ‘possess a large amount of discretionary power within the limits of their legal authority, and in the exercise of business judgment in the performance of their duties.’”<sup>53</sup> In reversing the decision of the trial court, the court rejected the plaintiffs’ argument that medical staff bylaws superseded the Corporate Bylaws.<sup>54</sup> Rather, the court reasoned that the medical staff’s powers were derivative of the powers of the Board, and that the medical staff bylaws “must originate from, and be authorized by, the Board pursuant to the Corporate Bylaws.”<sup>55</sup> The Corporate Bylaws specifically provided that “the business and the property of the Corporation shall be managed and controlled, . . . by a Board of Trustees” and that “all the corporate powers . . . except such as are otherwise provided for in these By Laws [sic] . . . shall be vested in and shall be exercised by the Members of the Board of Trustees.”<sup>56</sup> Therefore, the court concluded that “the medical staff has no authority over *any* corporate decisions unless specifically

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46. *Id.* ¶ 8, 621 N.W.2d at 153.

47. *Id.*

48. *Id.* ¶ 35, 621 N.W.2d at 161.

49. *Id.* ¶ 10, 621 N.W.2d at 153-54.

50. *See id.* ¶¶ 31-32, 621 N.W.2d at 150.

51. *Id.* ¶ 16, 621 N.W.2d at 154 (quoting S.D. CODIFIED LAWS § 47-23-13 (1989)) (alteration and emphasis in original).

52. *Id.* (quoting S.D. ADMIN. R. 44:04:04:02.01 (1995)) (emphasis in original).

53. *Id.* (quoting 18B AM. JUR. 2D *Corporations* § 1486 (2004)).

54. *Id.* ¶ 16, 621 N.W.2d at 154-55.

55. *Id.* ¶ 17, 621 N.W.2d at 155.

56. *Id.* (quoting ST. LUKE’S MIDLAND REGIONAL MED. CENTER, CORPORATE BYLAWS).

granted that power in the Corporate Bylaws<sup>57</sup> or by statute,<sup>58</sup> and the Board had the “authority to make business decisions without first consulting the medical staff.”<sup>59</sup>

As the court noted, in closing staff privileges the Board had specifically found that “the staff closures were in the Aberdeen community’s best interests” and were necessary to preserve profitable services at ASL.<sup>60</sup> The court reasoned that “[b]y preserving the profitable neurological services at ASL, the Board also insured that other unprofitable services would continue to be offered in the Aberdeen area.”<sup>61</sup> Therefore, the decision to close the medical staff was within the discretion of the Board exercising its business judgment.<sup>62</sup> “[T]he courts should not interfere in the internal politics and decision making of a private, nonprofit hospital corporation when those decisions are made pursuant to its Corporate Bylaws.”<sup>63</sup>

Notably, *Mahan v. Avera St. Luke’s* does not stand for the proposition that the Board can indiscriminately interfere with or impose credentialing decisions on economic grounds. The ASL Board’s authority was grounded in the actual language of ASL’s Corporate Bylaws and by state law. Further, the Board’s actions only impacted future credentialing decisions. As such, the court found little to distinguish the case before it with those decisions upholding the authority of a hospital to enter into exclusive provider contracts without the prior permission of the medical staff.<sup>64</sup> The case did not address the authority of the Board to terminate existing staff privileges or impose conflicts credentialing on a retroactive basis.

The case of *Medical Staff of Community Memorial Hospital of San Buenaventura v. Community Memorial Hospital of San Buenaventura*<sup>65</sup> illustrates the limits of a board’s authority when it unilaterally

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57. *Id.* ¶ 18, 621 N.W.2d at 155 (emphasis in original).

58. *Id.*

59. *Id.* ¶ 19, 621 N.W.2d at 156.

60. *Id.* ¶ 6, 621 N.W.2d at 153.

61. *Id.* ¶ 20, 621 N.W.2d at 156.

62. *Id.* ¶ 16, 621 N.W.2d at 154.

63. *Id.* ¶ 20, 621 N.W.2d at 156.

64. *Id.* ¶ 26, 621 N.W.2d at 158.

65. No. CIV 219107 (Ventura County, Cal. Super. Ct.) (on file with author); see AMERICAN MEDICAL ASSOCIATION, *A Victory for Physicians*, at <http://www.ama-assn.org/ama/pub/category/13815.html> (Aug. 23, 2004); see also Plaintiff’s Second Amended Complaint, *San Buenaventura* (No. CIV 219107) (on file with author).

attempts to alter the medical staff bylaws and retroactively remove the staff privileges of physicians. In *Medical Staff of Community Memorial Hospital of San Buenaventura*, the hospital sought to unilaterally amend the medical staff bylaws to, among other things, establish a conflict of interest policy that required physicians to sign a conflict of interest statement that purported to make staff members ineligible for holding office if they had an ownership interest in any entity engaged in a business that competed with the hospital.<sup>66</sup> The medical staff sued for breach of contract, claiming that the amendments violated the medical staff bylaws, California law, and constituted an unlawful interference with the role of the medical staff in credentialing staff members.<sup>67</sup>

The hospital moved to dismiss on the grounds that the medical staff, as an unincorporated association, did not have standing to sue the governing body of the hospital.<sup>68</sup> The court found that the medical staff had standing to bring the action on behalf of the entire medical staff, but not the individual members.<sup>69</sup> The parties eventually settled after the medical director resigned, with the hospital agreeing, among other things, that the medical staff bylaws could not be amended or changed unilaterally by the hospital administrator.<sup>70</sup>

### III. STATE AND MEDICAL ASSOCIATION RESPONSES TO CONFLICTS CREDENTIALING

Twenty states have enacted legislation addressing whether and how a hospital can consider economic factors in the credentialing process. The content and the potential protection afforded physicians by these statutes vary. Ten states permit hospitals to use economic criteria in credentialing;<sup>71</sup> whereas, ten other states and the District of Columbia restrict hospitals from using economic factors in credentialing decisions.<sup>72</sup>

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66. *San Buenaventura*, No. CIV 219107.

67. *Id.*

68. *Id.*

69. *Id.*

70. *Id.*

71. FLA. STAT. ANN. § 395.0191 (West 2001 & Supp. 2004); GA. CODE ANN. § 31-7-7 (2001); IND. CODE ANN. § 16-21-2-5 (1996 & West Supp. 2004); IOWA CODE § 135B.7 (2001 & Supp. 2004); KAN. STAT. ANN. § 65-431 (2002); MD. CODE ANN., HEALTH-GEN. § 19-319 (1982 & Michie Supp. 2003); N.C. GEN. STAT. § 131E-85 (2002); N.Y. PUB. HEALTH LAW § 2801-b (McKinney 2001 & Supp. 2005).

72. CAL. WELF. & INST. CODE § 14087.28 (2002 & West Supp. 2005); COLO.

The practice of conflicts credentialing has divided the medical profession. The AMA and the American College of Medical Quality (ACMQ) have both issued position statements opposing the practice. “The AMA opposes the use of economic criteria not related to quality to determine an individual physician’s qualifications. . . .”<sup>73</sup> The ACMQ has declared that “[c]redentialing [practices] must be the exclusive product of qualified and objective peer review, utilizing criteria directly related to the quality of patient care in which neither over nor under-utilization of medical resources is accepted.”<sup>74</sup> Conversely, the American Hospital Association (AHA) asserts that hospitals must be allowed to establish policies necessary to protect the hospitals economic interests.<sup>75</sup>

Because JCAHO standards address the organization and governance of the medical staff, they shape institutional procedures related to credentialing.<sup>76</sup> The current JCAHO standards anticipate medical staff self-governance which can be implemented by the adoption of bylaws and rules regulating medical staff activities.<sup>77</sup> Importantly, the standards allow neither the medical staff nor the governing board to unilaterally amend the bylaws.<sup>78</sup> However, hospital and other medical facility interests have

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REV. STAT. § 25-3-103.7 (2003); D.C. CODE ANN. § 44-507 (2004); IDAHO CODE § 41-3920 (Michie 2003); 210 ILL. COMP. STAT. 85/2(b) (1993); LA. REV. STAT. ANN. § 37:1301 (1999 & West Supp. 2005); MASS. ANN. LAWS ch. 111, § 51C (2003); R.I. GEN. LAWS § 23-17-52 (2001); TENN. CODE ANN. § 68-11-205, §68-11-227 (2001 & Supp. 2004); TEX. HEALTH & SAFETY CODE ANN. § 241.1015 (1999 & Vernon Supp. 2004-2005); VA. CODE ANN. § 32.1-134.1 (2004).

73. American Medical Association, Policy H-230.976 Economic Credentialing, available at [http://www.ama-assn.org/apps/pf\\_new/pf\\_online?f\\_n=resultLink&doc=policyfiles/HnE/H-230.976.HTM&s\\_t=H-230.976&catg=AMA/HnE&catg=AMA/BnGnC&catg=AMA/DIR&&nth=1&&st\\_p=0&nth=1&](http://www.ama-assn.org/apps/pf_new/pf_online?f_n=resultLink&doc=policyfiles/HnE/H-230.976.HTM&s_t=H-230.976&catg=AMA/HnE&catg=AMA/BnGnC&catg=AMA/DIR&&nth=1&&st_p=0&nth=1&) (last visited Feb. 8, 2005).

74. American College of Medical Quality, Policy 19 Economic Credentialing (adopted Nov. 13, 1997), available at <http://www.acmq.org/profess/policy19.htm>.

75. Letter from Rick Pollack, Executive Vice President, American Hospital Association to The Honorable Janet Rehnquist, Office of Inspector General, available at <http://www.aha.org/aha/advocacy-grassroots/advocacy/comment/2003/cl030205credential.html> (last visited Feb. 8, 2005).

76. See Judith J. Semo, *Hospital-Medical Staff Relations: Strengthening Fragile Relationships*, AMERICAN SOCIETY OF ANESTHESIOLOGISTS NEWSLETTER, Dec. 2003, available at <http://www.asahq.org/newsletters/2003/12-03/semo.html>.

77. JCAHO STANDARDS, MS 2.1, at <http://www.jcrinc.com/subscribers/perspectives.asp?durki=2837&site=10&return=6063#d> (effective date Jan. 7, 2002) (“Medical staff bylaws and rules and regulations are adopted by the medical staff and approved by the governing body before becoming effective.”).

78. *Id.* (“Neither body may unilaterally amend the medical staff bylaws or

recently begun to lobby JCAHO, arguing that facility boards should have “absolute control over medical staff composition and function.”<sup>79</sup> The ability to unilaterally amend medical staff bylaws would follow from such increased control.<sup>80</sup> Despite the lobbying effort, JCAHO recently proposed a rule that would authorize a citation of noncompliance where bylaws permitted unilateral amendment.<sup>81</sup> If it is adopted, the JCAHO rule would be retroactive to 2004.<sup>82</sup>

#### IV. STATUTORY CHALLENGES TO PATIENT REFERRALS AND CONFLICTS CREDENTIALING

Physicians have been largely unsuccessful at challenging the rights of hospitals to enter into exclusive contracts or engage in other forms of economic credentialing. Courts and the FTC have both concluded that exclusive provider contracts have pro-competitive effects that often improve the quality of patient care.<sup>83</sup> Further, physicians have had mixed success claiming that the imposition of conflicts credentialing was a breach of contract/bylaws between the physician and the hospital, especially when the credentialing is only used prospectively to exclude physicians from existing medical staffs.<sup>84</sup>

Recently, medical associations and physician groups have begun to challenge conflicts credentialing as violating the federal anti-kickback statutes and anti-trust laws.<sup>85</sup> In this section, the authors discuss applicable statutes that have most recently been cited and two current cases where physicians have had some initial success at challenging the retroactive imposition of conflicts credentialing.

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rules and regulations.”).

79. See Semo *supra* note 76.

80. See *id.*

81. *Id.*

82. *Id.*

83. See *supra* notes 31, 32 and accompanying text.

84. See *Mahan v. Avera St. Lukes*, 2001 SD 9, 621 N.W.2d 150 (2001); see also *supra* text accompanying notes 35-64.

85. See *Murphy v. Baptist Health*, CV 2004-2002 (using anti-kickback laws to challenge implementation of conflicts credentialing); *Biddulph et. al. v. HCA, Inc. & E. Idaho Health Servs., Inc.*, Case No. CV-04-1219 (using antitrust laws to challenge conflicts credentialing).

A. *Challenging Conflicts Credentialing with the Federal Anti-Kickback Statute: Are Staff Privileges “Remuneration”?*

The federal Anti-Kickback Statute<sup>86</sup> prohibits the knowing and willful offer, solicitation, payment or receipt of any remuneration in return for or in order to induce either any referral for items or services covered under any federal health care program, or the purchase, lease or ordering of such items or services.<sup>87</sup> For purposes of the Anti-Kickback Statute, a “federal health care program” is defined to include a broad range of federally-funded health care programs, including Medicare, Medicaid, TRICARE, CHAMPUS, the Children’s Health Insurance Program, and programs funded by Maternal and Child Health Block Grants or Social Services Block Grants.<sup>88</sup>

The intent of the Anti-Kickback Statute is to prohibit the direct or indirect receipt and payment of remuneration in connection with the referral of patients and activities related to the acquisition of goods, facilities, services and other items paid for by the federal health care program.<sup>89</sup>

On December 2, 1999, the AMA requested that the Health and Human Services-Office of Inspector General (OIG) publish a fraud and abuse alert on the practice of exclusive or conflict credentialing.<sup>90</sup> In that letter, the AMA asserted that medical staff privileges were a form of remuneration and complained that the practice of exclusive or conflicts credentialing:

requires physicians seeking medical staff membership and privileges at a specific hospital to agree to admit patients exclusively or principally in a specific hospital only if they agree to refer all or most of their patients to that hospital. Some exclusive credentialing policies go further, prohibiting medical staff members from any association (investment, employment or contractual) with facilities that compete with the hospital, even if the competing facility would be the better choice from a quality of care

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86. 42 U.S.C. § 1320a-7b(b) (2000).

87. *Id.*

88. *See* 42 U.S.C. § 1320a-7b(f)(1) (2000); Rules and Regulations, 64 Fed. Reg. 63518, 63538-39 (Nov. 19, 1999).

89. 42 U.S.C. § 1320a-7b(b).

90. Letter from AMA to OIG dated December 2, 1999 (on file with author).

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perspective.<sup>91</sup>

The AMA supplemented this request in a second letter to the OIG in September 2002.<sup>92</sup>

In response, the OIG issued a request for public comments regarding the development of possible guidance addressing certain credentialing practices.<sup>93</sup> The OIG's Solicitation of Public Comments on Certain Credentialing Practices referred to the AMA's concern that "an increasing number of hospitals are refusing to grant staff privileges to physicians who (1) own or have other financial interests in, or leadership positions with, competing health care entities, (2) refer to competing health care entities, or (3) fail to admit some specified percentage of their patients to the hospital."<sup>94</sup>

The OIG recognized the historical precedent that the denial of a physician's hospital privileges was "rarely actionable" under the Federal Anti-Kickback laws.<sup>95</sup> The OIG also noted the increase of physician ownership in freestanding facilities, and stated, "[t]hese physicians may be in a position to steer profitable business or patients to their own competing business through their control of referrals."<sup>96</sup>

The OIG reasoned that "a credentialing policy that categorically refuses privileges to physicians with significant conflict of interest would not appear to implicate that [A]nti-[K]ickback [S]tatute in most situations."<sup>97</sup> However, the OIG stated its concern that "discretionary decision-making" could raise certain Anti-Kickback risks.

Several credentialing practices have been brought to our attention that give the privilege-granting hospital discretion to evaluate the "financial conflict" created by a physician's outside business interests and permit the

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91. *Id.*

92. See Letter from Michael D. Maves, AMA to Kevin G. McAnaney, Chief, OIG (Sept. 30, 2002), available at [http://www.ama-assn.org/ama1/pub/upload/mm/395/sept\\_ltr\\_oig.doc](http://www.ama-assn.org/ama1/pub/upload/mm/395/sept_ltr_oig.doc); see also William B. Monnig, *Report of the Organized Medical Staff Section Governing Council, I-04 REPORT B* (AMA, Chicago, IL), at <http://www.ama-assn.org/ama1/pub/upload/mm/21/i04rep-b.doc> (last visited Mar. 3, 2005) (providing a timeline of AMA/OIG communications on "economic and exclusive credentialing").

93. Annual Comment Notice, 67 Fed. Reg. 72894 (Dec. 9, 2002).

94. *Id.* at 72895.

95. *Id.*

96. *Id.*

97. *Id.*

physician to retain privileges subject to periodic review. Such discretionary decision-making appears to raise substantial risks under the [A]nti-[K]ickback [S]tatute (i.e., privileges are conditioned on a sufficient flow of referred business).<sup>98</sup>

The OIG also noted that some hospitals were conditioning privileges on referrals other than the minimum necessary for clinical proficiency.<sup>99</sup> The OIG concluded that privileges can be remuneration and that certain types of credentialing decisions can violate the Anti-Kickback Statute: “Certain medical staff credentialing practices may implicate the [A]nti-[K]ickback [S]tatute. For example, 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.”<sup>100</sup> Whether privileges were remuneration, and whether a hospital’s use of conflicts credentialing could be justified under certain circumstances, were therefore important considerations in determining whether conflicts credentialing could violate the Anti-Kickback Statute.

The AMA and the AHA both provided comments in response to the OIG’s solicitation. The organizations took conflicting positions on a number of issues, including whether hospital privileges constituted remuneration under the Anti-Kickback Statute. The AHA argued that privileges were remuneration and “do not involve the transfer of something of value from a hospital to a physician.”<sup>101</sup> As the AHA stated in response to the OIG’s solicitation for comments:

In granting privileges . . . a hospital transfers no cash or any equivalent in-kind benefit to the physician. Rather, to the extent a physician receives an economic benefit related to hospitalized patients, that benefit derives solely from the payment made to the physician’s patient or his/her insurer for professional services rendered. There is no remuneration, in cash or in kind, from the hospital, which neither provides patient referrals nor performs the income-generating services.<sup>102</sup>

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98. *Id.*

99. *Id.* at 72896.

100. Notices, 69 Fed. Reg. 32012, 32023 (June 8, 2004).

101. Letter from Rick Pollack to Janet Rehnquist, *supra* note 75.

102. *Id.*

The AMA reasoned, on the other hand, that privileges were remuneration: “Clinical privileges are crucial to physicians. Without clinical privileges, physicians cannot admit patients to a hospital for treatment. Most, if not all, physicians cannot practice medicine effectively without the ability to admit patients to a hospital when necessary or to provide consultation when requested.”<sup>103</sup>

The Anti-Kickback Statute does not provide a private right of action. The Anti-Kickback Statute provides criminal and civil penalties for individuals and entities that violate the statute unless the payment and receipt of “remuneration” fits into a safe harbor regulation promulgated by the Secretary of the Department of Health and Human Services (DHHS).<sup>104</sup> Each offense under the Anti-Kickback Statute is punishable by a fine of up to \$25,000 and imprisonment for up to five years.<sup>105</sup> Violators are also subject to exclusion from the federal health care program upon a determination of violation by the DHHS regardless of whether a criminal conviction has been obtained.<sup>106</sup>

Prior to 1997, the OIG did not have the authority to impose civil penalties upon violators and the OIG entered into significant monetary settlements with individuals and entities under investigation for potential violations of the Anti-Kickback Statute. However, the Balanced Budget Act of 1997, Congress amended the civil monetary provisions to allow DHHS to recover treble damages plus \$50,000 for each violation of the Anti-Kickback Statute.<sup>107</sup>

Even though the statute does not provide for a private right of action, the Anti-Kickback Statute can be used to challenge conflict credentialing policies. Courts have held that contracts that contravene the Anti-Kickback statute violate public policy and are therefore unenforceable, “irrespective of whether anyone can be prosecuted criminally (or civilly) in connection with that agreement.”<sup>108</sup> Consistent with the statutory language, courts have interpreted the definition of remuneration broadly: “The text

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103. Letter from Michael D. Maves, AMA, to Janet Rehnquist, OIG (Feb. 6, 2003) (on file with author).

104. 42 U.S.C. § 1320a-7b (2000).

105. 42 U.S.C. § 1320a-7b(b)(1)(B).

106. 42 U.S.C. § 1320a-7b(a)(6)(i).

107. 42 U.S.C. § 1320a-7a(a)(7) (current version).

108. *Nursing Home Consultants, Inc. v. Quantum Health Serv., Inc.*, 926 F. Supp. 835, 843 (E.D. Ark. 1996); *see also* *Zimmer, Inc., v. Nu Tech Med., Inc.*, 54 F. Supp. 2d 850, 863 (N.D. Ind. 1999).

refers to ‘any remuneration.’ That includes not only sums for which no actual service was performed but also those amounts for which some professional time was expended. ‘Remunerates’ is defined as ‘to pay an equivalent for service.’<sup>109</sup> The Anti-Kickback Statute may provide a basis for challenging conflicts credentialing in those circumstances in which the courts find that physician privileges are a form of remuneration.

Such a legal theory is being pursued in a case pending before the Arkansas Supreme Court. In *Murphy v. Baptist Health*,<sup>110</sup> plaintiffs used federal and state anti-kickback laws to challenge the unilateral implementation of conflicts credentialing. Baptist Health Medical Center is a general purpose hospital that is part of the Baptist Health medical system. The plaintiff physicians have staff privileges at Baptist Health and also shareholders of the Little Rock Cardiology Clinic.<sup>111</sup> The clinic in turn owned a minority ownership interest in the Arkansas Heart Hospital, a competitor of Baptist Health.<sup>112</sup>

Baptist Health adopted a conflict policy which required professional staff members to disclose direct or indirect interests in competing hospitals and declared that any physician with such an interest was ineligible for initial or renewed appointment.<sup>113</sup> The credentialing policy further provided that any physician granted privileges “who subsequently acquires or holds an ownership interest or investment interest in a competing hospital, immediately ceases to be qualified to hold appointment or clinical privileges at Baptist Health. . . .”<sup>114</sup> In 2004, Baptist Health notified the plaintiff physicians that their ownership interest disqualified them from staff appointments and privileges and that effective in the near future they would not be permitted to schedule future procedures or appointments at the hospital.<sup>115</sup>

The physicians sued, alleging that the Baptist Health policy violated the Federal Anti-Kickback Statute,<sup>116</sup> by creating a system of

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109. *United States v. Bay State Ambulance and Hosp. Rental Serv., Inc.*, 874 F.2d 20, 30 (1st Cir. 1989) (citing WEBSTER THIRD NEW INTERNATIONAL DICTIONARY (1966)).

110. *Murphy v. Baptist Health*, No. CV2004-2002, (13th Div. Civ. Ct. Ark. filed Feb. 24, 2004).

111. *Id.*

112. Plaintiff's Complaint ¶ 3, *Murphy* (No. CV2004-2002).

113. *Id.* ¶ 5.

114. *Id.* ¶ 7.

115. *Id.* ¶ 15.

116. *Id.* ¶ 1. Plaintiffs also alleged violations of the Arkansas Medicaid Fraud

rewarding appointments and privileges to physicians in exchange for increased referrals to Baptist Health, which “constitutes offering and paying prohibited indirect remuneration to physicians in exchange for these referrals. . . .”<sup>117</sup> The physician plaintiffs sought to enjoin implementation of such credentialing as contrary to federal law and interfering with their relationships with patients and with referring physicians.<sup>118</sup>

In response to plaintiffs’ motion for a preliminary injunction, Baptist Hospital relied on *Mahan v. Avera St. Lukes*’ and argued that it was in the best interests of the community for the doctors to not be extended staff privileges at Baptist because the loss of loss of patients would jeopardize the other non-profit functions of the hospital.<sup>119</sup> The trial court granted the preliminary injunction, holding that the granting of privileges to physicians under the facts alleged by plaintiffs did appear to be a violation of the federal anti-kick back laws and other statutes cited by the plaintiffs.<sup>120</sup> The case is currently on appeal to the Arkansas Supreme Court.

#### B. *Challenging Conflicts Credentialing Through Anti-Trust Law*

Sections 1 and 2 of the Sherman Act<sup>121</sup> provide an additional basis for challenging conflicts credentialing policies. Significant legal and factual hurdles exist, however, with respect to the application of either section of the Sherman Act.

To prevail under section 1 of the Sherman Act, the plaintiff must establish the existence of a conspiracy in restraint of trade. This requires the existence of multiple parties capable of entering into a conspiracy.<sup>122</sup> Whether a hospital and its staff are distinct entities capable of conspiring varies among jurisdictions.<sup>123</sup> Some jurisdictions view the medical staff itself as a group of distinct

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Act, the Arkansas Medicaid Fraud False Claims Act, the Arkansas Deceptive Trade Practices Act and two common law theories. *Id.*

117. *Id.* ¶ 29.

118. *Id.* ¶¶ 31-32, 54-55.

119. *Murphy v. Baptist Health*, CV 2004-2002, (13th Div. Civ. Ct. Ark. Mar. 22, 2004) (order granting preliminary injunction).

120. *Id.*

121. 15 U.S.C. §§ 1-2 (2000).

122. *Copperweld Corp. v. Independence Tube Corp.*, 467 U.S. 752, 769-72 (1984).

123. *Compare* *Weiss v. York Hosp.*, 745 F.2d 786, 814-17 (3d Cir. 1984) (finding hospital and staff were one entity and as a matter of law could not conspire with each other), *with* *Bolt v. Halifax Hosp. Med. Ctr.*, 891 F.2d 810, 819 (11th Cir. 1990) (finding hospital and its staff were separate entities capable of conspiring).

individuals capable of conspiring among themselves.<sup>124</sup>

To bring a section 2 Sherman Act claim, the plaintiff claiming monopolization or attempted monopolization must be a competitor of the hospital or consumer of the hospital's services to have standing to bring the claim.<sup>125</sup> Additionally, the plaintiff must demonstrate that the hospital possessed the intent to monopolize.<sup>126</sup> The failure to prevail on one section of the Sherman Act is not determinative of the ability to prevail on the other.

The use of the Sherman Act to challenge conflicts credentialing is illustrated in the matter of *Biddulph/Mountain View Hospital v. HCA/Eastern Idaho Regional Medical Center*,<sup>127</sup> currently pending in the District Court of the Seventh Judicial District in Idaho. In that case, the Trustees of an Eastern Idaho Regional Medical Center (EIRMC), a community hospital located in Idaho Falls, unilaterally adopted a Medical Staff Development Plan (MSDP) that purported to "supplement" the medical staff bylaws.<sup>128</sup> The MSDP required physicians to disclose financial relationships or investment in competing facilities and empowered the board to remove a "practitioner's appointment and clinical privileges . . . if the [Trustees determine] by objective criteria that a practitioner is diverting patients to other facilities. . . for reasons related to that practitioner's financial or other gain."<sup>129</sup>

In 2003, without prior notice, the board voted to terminate five physicians with staff privileges at EIRMC who were also substantial investors in Mountain View Hospital (Mountain View), a twenty-bed-surgical-andobstetric hospital established by several local physicians.<sup>130</sup> In response, Mountain View and four of the five allegedly conflicted physicians filed an eight-count complaint in state court, alleging breach of contract, tortious interference with

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124. *Nurse Midwifery Assocs. v. Hibbett*, 918 F.2d 605, 612-13 (6th Cir. 1990).

125. 15 U.S.C. § 2 (2000); *see, e.g.*, *White v. Rockingham Radiologists, Ltd.*, 820 F.2d 98, 104 (4th Cir. 1987) (holding party could not maintain action against alleged monopolist because party was neither provider nor consumer of offered services).

126. *See White*, 820 F.2d at 104 (holding that one of the elements of Section 2 is a "willful acquisition" of monopoly power).

127. *Biddulph v. HCA, Inc.*, No. CV-04-1219 (D. Idaho filed Aug. 6, 2004).

128. *Id.* at 10.

129. *Id.*

130. *Id.*; *see* IDAHO CODE § 48-104 (2004) ("A contract, combination, or conspiracy between two or more persons in unreasonable restraint of Idaho commerce is unlawful.").

prospective economic advantage, and two counts under the Idaho Competition Act (conspiracy to adopt anti-competitive policies<sup>131</sup> and attempted monopolization).<sup>132</sup> The plaintiffs alleged that the MSDP was an anti-competitive policy targeting new hospitals in the Idaho Falls area.<sup>133</sup>

Reasoning that the Idaho Competition Act<sup>134</sup> was substantially similar to the Federal Sherman Act, the trial court looked to federal law to determine whether the plaintiffs could state a claim for conspiracy or attempted monopolization.<sup>135</sup> The trial court dismissed the section 1 conspiracy claim, reasoning that the board could not conspire with itself.<sup>136</sup> The trial court, however, refused to dismiss the section 2 monopolization claim.<sup>137</sup>

In the Sherman Act section 2 claim, the plaintiffs' alleged that the MSDP was an anti-competitive policy targeting new hospitals in the Idaho Falls area.<sup>138</sup> EIRMC argued that it could refuse to deal with competitors as a matter of law.<sup>139</sup> Plaintiffs' asserted that a refusal to deal violated section 2 if the actor was a conceded monopolist.<sup>140</sup> The court, in denying the motion to dismiss, reasoned that the plaintiffs had alleged facts raising an issue as to whether EIRMC had monopoly power in the Idaho Falls market and whether EIRMC was willfully using such power in adopting and

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131. *Id.*; see IDAHO CODE §48-105 (2004) ("It is unlawful to monopolize, attempt to monopolize, or combine or conspire to monopolize any line of Idaho commerce.").

132. *Biddulph*, CV-04-1219, at 27.

133. *Id.*

134. IDAHO CODE § 48-104 (2004).

135. See *id.* § 48-102(3) (directing court to utilize the interpretation of federal statutes in interpreting comparable Idaho statutes in the absence of reported Idaho appellate decisions). Here, the court looked to federal case law from the Ninth Circuit Court of Appeals. *Biddulph*, CV-04-1219, at 23-24.

136. In so reasoning, the trial court looked to whether one of the decision makers sat on the board or was a member of the medical staff. *Biddulph*, CV-04-1219, at 25-27. Although many circuits have held that a hospital cannot conspire with its medical staff, other courts have held that medical staff members could conspire with the hospital because medical staff members are generally not officers or directors of the hospital. Compare *Weiss v. York Hosp.*, 745 F.2d 786, 814-17 (3d Cir. 1984) (holding medical staff could conspire with hospital), with *Oltz v. St. Peter's Cmty. Hosp.*, 861 F.2d 1440, 1450 (9th Cir. 1988) (holding medical staff could not conspire with hospital). Whether the medical staff can conspire with the hospital therefore depends on whether the members are considered officers or directors of the hospital.

137. *Biddulph*, CV-04-1219, at 31-32.

138. *Id.* at 27.

139. *Id.* at 28.

140. *Id.* at 28-29.

implementing the MSDP in 2002 through 2004.<sup>141</sup> The case has been set for trial and the parties are engaged in discovery.<sup>142</sup>

## V. CONCLUSION

Continued reductions in the Medicare-physician-fee schedule and payment for health care will increase competition for health care dollars. Reduced reimbursement and increased competition for patients will also continue to create tension between hospitals and their medical staff. Physicians will position themselves as competitors to hospitals as they seek to increase their revenues through ownership in freestanding facilities and joint ventures with hospitals. In some markets, hospitals will have no choice but to allow physicians to compete against them because utilizing a conflict of interest credentialing policy would drive physicians to competing hospitals. In other markets, hospitals will succeed in using conflict of interest credentialing policies as a method of improving the hospital's strategic position and preserving its economic viability.

Conflicts and other forms of economic credentialing will only increase as community and other general hospitals compete with freestanding healthcare facilities. Although hospitals have the power to implement economic credentialing in certain circumstances, the manner and method of how this is done depends on a number of factors, including the terms of the corporate bylaws, state statutes, and whether the credentialing is done prospectively or is meant as a mechanism to retroactively remove or punish alleged competing physicians. The law in this area is far from settled and it will continue to evolve as physicians and hospitals deliver patient care in a highly regulated environment while facing rising health care costs and declining reimbursement.

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141. *Id.*

142. *Biddulph v. HCA, Inc.*, ROA Report (on file with author).