FUNDAMENTALS OF HEALTH CARE LAW

6.5 CLE Hours including
1.5 Ethics Hours | 1 Trial Practice Hour

Sponsored By: Institute of Continuing Legal Education
Who are we?

**SOLACE** is a program of the State Bar of Georgia designed to assist those in the legal community who have experienced some significant, potentially life-changing event in their lives. SOLACE is voluntary, simple and straightforward. SOLACE does not solicit monetary contributions but accepts assistance or donations in kind.

How does SOLACE work?

If you or someone in the legal community is in need of help, simply email SOLACE@gabar.org. Those emails are then reviewed by the SOLACE Committee. If the need fits within the parameters of the program, an email with the pertinent information is sent to members of the State Bar.

What needs are addressed?

Needs addressed by the SOLACE program can range from unique medical conditions requiring specialized referrals to a fire loss requiring help with clothing, food or housing. Some other examples of assistance include gift cards, food, meals, a rare blood type donation, assistance with transportation in a medical crisis or building a wheelchair ramp at a residence.

Contact SOLACE@gabar.org for help.
The purpose of the SOLACE program is to allow the legal community to provide help in meaningful and compassionate ways to judges, lawyers, court personnel, paralegals, legal secretaries and their families who experience loss of life or other catastrophic illness, sickness or injury.

TESTIMONIALS

In each of the Georgia SOLACE requests made to date, Bar members have graciously stepped up and used their resources to help find solutions for those in need.

A solo practitioner’s quadriplegic wife needed rehabilitation, and members of the Bar helped navigate discussions with their insurance company to obtain the rehabilitation she required.

A Louisiana lawyer was in need of a CPAP machine, but didn’t have insurance or the means to purchase one. Multiple members offered to help.

A Bar member was dealing with a serious illness and in the midst of brain surgery, her mortgage company scheduled a foreclosure on her home. Several members of the Bar were able to negotiate with the mortgage company and avoided the pending foreclosure.

Working with the South Carolina Bar, a former paralegal’s son was flown from Cyprus to Atlanta (and then to South Carolina) for cancer treatment. Members of the Georgia and South Carolina bars worked together to get Gabriel and his family home from their long-term mission work.

Contact SOLACE@gabar.org for help.
Dear ICLE Seminar Attendee,

Thank you for attending this seminar. We are grateful to the Chairperson(s) for organizing this program. Also, we would like to thank the volunteer speakers. Without the untiring dedication and efforts of the Chairperson(s) and speakers, this seminar would not have been possible. Their names are listed on the AGENDA page(s) of this book, and their contributions to the success of this seminar are immeasurable.

We would be remiss if we did not extend a special thanks to each of you who are attending this seminar and for whom the program was planned. All of us at ICLE hope your attendance will be beneficial as well as enjoyable. We think that these program materials will provide a great initial resource and reference for you.

If you discover any substantial errors within this volume, please do not hesitate to inform us. Should you have a different legal interpretation/opinion from the speaker’s, the appropriate way to address this is by contacting him/her directly.

Your comments and suggestions are always welcome.

Sincerely,
Your ICLE Staff

Jeffrey R. Davis
Executive Director, State Bar of Georgia

Tangela S. King
Director, ICLE

Rebecca A. Hall
Associate Director, ICLE
AGENDA

PRESIDING:  Rod G. Meadows, Program Co-Chair; Meadows, Macie & Sutton, P.C., Stockbridge  
Richard D. Sanders, Program Co-Chair; The Sanders Law Firm PC, Atlanta

7:45  REGISTRATION AND CONTINENTAL BREAKFAST  
(All attendees must check in upon arrival. A removable jacket or sweater is recommended.)

8:00  WELCOME AND UPDATE  
Lynnette R. Rhodes, Chair, Health Law Section; Georgia Department of Community Health, Atlanta

8:05  WELCOME  
D’Andrea J. Morning, Chair, Georgia Academy of Healthcare Attorneys; Grady Health System, Atlanta

8:10  INTRODUCTION AND PROGRAM OVERVIEW  
Rod G. Meadows

8:15  FEDERAL HEALTHCARE REGULATIONS (INCLUDING ETHICAL CONSIDERATIONS)  
Robert M. Keenan, III, King & Spalding LLP, Atlanta  
Charlotte A. Combre, BakerHostetler LLP, Atlanta  
Jonathan L. Rue, Parker Hudson Rainer & Dobbs LLP, Atlanta

9:45  BREAK

10:00  STATE HEALTHCARE REGULATIONS  
Kathlynn Butler Polvino, KBP Law, P.C., Atlanta  
Rachel L. King, Georgia Department of Community Health, Atlanta  
Roxana D. Tatman, Georgia Department of Community Health, Atlanta

11:00  THE CRIMINAL SIDE OF HEALTHCARE LAW  
Brian F. McEvoy, Polsinelli PC, Atlanta

11:30  HOSPITAL MEDICAL STAFF ISSUES  
Rod G. Meadows  
John W. Ray, Ray & Gregory LLC, Atlanta

12:00  LUNCH AND PRESENTATION  
LEGENDS OF GEORGIA HEALTHCARE LAW SERIES: HEALTHCARE LAW EDUCATION IN GEORGIA  
Charity Scott, Georgia State University, School of Law, Atlanta

1:15  MEDICAL MALPRACTICE LITIGATION: PLAINTIFF’S PERSPECTIVE  
James H. Webb, Jr., Webb & Taylor LLC, Peachtree City
1:45  MEDICAL MALPRACTICE LITIGATION: DEFENDANT’S PERSPECTIVE  
   Lindsay A. Forlines, Weathington McGrew LLC, Atlanta

2:15  BREAK

2:30  HOSPITAL AFFILIATIONS  
   Michelle A. Williams, Alston & Bird LLP, Atlanta  
   W. Wright Banks, Jr., Deputy Attorney General, Georgia Office of the Attorney General, Atlanta

3:00  THE TOP THREE HEALTHCARE ISSUES FOR VARIOUS SUB-SPECIALISTS  
   • Hospitals  
      Christy D. Jordan, Southeast Georgia Health System, Brunswick  
   • Mental Health  
      Robert B. Remar, Rogers & Hardin LLP, Atlanta  
   • Long Term Healthcare  
      Brittany H. Cone, Hall Booth Smith PC, Atlanta

4:00  ADJOURN
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FEDERAL HEALTHCARE REGULATIONS (INCLUDING ETHICAL CONSIDERATIONS)

Robert M. Keenan, III, King & Spalding LLP, Atlanta

Charlotte A. Combre, BakerHostetler LLP, Atlanta

Jonathan L. Rue, Parker Hudson Rainer & Dobbs LLP, Atlanta
Mass hacking incidents have become commonplace

- Cybercriminals increasingly are targeting health data.
- Healthcare data are perceived as **vulnerable**:
  - Goals of consumer access and sharing among healthcare providers increase access points for cybercriminals.
- Healthcare data are **valuable**:
  - Used to make false insurance claims in addition to identity theft.
  - May be worth ten times the value of credit card numbers alone on the black market.
“Health Insurance Portability and Accountability Act of 1996” Administrative Simplification

• Privacy
• Security
• Breach Notification

• Major statutory changes passed as part of stimulus bill signed into law February 17, 2009 (Pub. Law 111-005, Title XIII, Subtitle D; 42 U.S.C. § 17921 et seq.) (the “HITECH Act”).


HIPAA Administrative Simplification

• Applies to the following “covered entities”:
  – Health plans (including group health plans).
  – Health care providers that transmit any health information electronically in connection with a HIPAA-regulated health care financing transaction.
  – Health care clearinghouses.

• Applies directly to “business associates” as per HITECH and HITECH regulations.
Business Associate Contracts

Performs or assists in the performance of a covered entity function or activity; or

or

Performs certain services to or for a covered entity;

and

Creates, receives, maintains or transmits PHI

Includes subcontractors of business associates as a result of HITECH regulations.

Privacy Regulation – Scope

• Applies to covered entities and business associates with regard to “protected health information” or “PHI”

• PHI is individually identifiable information created/received by a covered entity (including demographic information) that relates to:
  – the provision of health care to an individual, or
  – the past, present or future physical or mental health or condition of an individual
  – the past, present or future payment for health care of an individual
Basic Privacy Rule Requirement

Cannot use or disclose PHI except as permitted or required by regulations.

Permitted Uses and Disclosures

• Without “authorization”
  – Treatment, payment and health care operations (TPO)
  – “National priority” purposes, such as for regulatory oversight of government healthcare programs, law enforcement and state law reporting obligations
  – Other specified purposes

• Otherwise, need the individual’s specific, written authorization.
**Key Compliance Obligations**

- Policies and procedures.
- Training.
- Minimum necessary use/disclosure.
- Business associate agreements.
- Administration of individual rights (access, amendment, accounting).
- Notice of privacy practices.
- State law – including in Georgia a constitutional right of privacy when health information is requested by the government.

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**Security Rule - Generally**

- Applies to PHI transmitted or maintained electronically.
- Designed to ensure confidentiality, integrity and availability of electronic PHI.
- Key starting point is a security risk assessment.
- Compliance measures should be tailored to identified risks.
### Categories of Specific Security Measures

- Administrative safeguards (overall security management process, workforce security, workforce training, sanctions mechanism).
- Physical safeguards (facility access, workstation security, device and media controls).
- Technical safeguards (unique user ID, automatic logoff, audit controls, data integrity mechanisms).
- Organizational requirements (business associate agreements).
- Policies and procedures/documentation.

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### HITECH Act - Breach Notification

42 U.S.C. § 17932  
45 C.F.R. § 164.400 et seq.

- A CE that discovers a breach of “unsecured” PHI shall notify affected individuals.
- “Unsecured” PHI means PHI that is not secured through use of a technology/methodology listed in guidance issued by HHS.
  - Focus is on encryption and destruction.
HITECH Act - Breach Notification

• “Breach” originally defined to mean an unauthorized acquisition, access, use or disclosure of PHI that poses a significant risk of financial, reputational or other harm to the individual.

HITECH Act - Breach Notification

• As revised in the HITECH regulations, “breach” is presumed, unless the CE or BA determines that there is a low probability that the PHI has been compromised based on a risk assessment, to include at least the following:
  – Nature and extent of PHI involved;
  – Unauthorized person who accessed or received PHI;
  – Whether PHI actually was acquired or viewed; and
  –Extent to which risk has been mitigated.
HITECH Act - Breach Notification

- Notice to individuals w/o unreasonable delay and not later than 60 days after discovery.
- Media notice required if breach involves more than 500 residents of a state or jurisdiction (meaning a geographic area smaller than a state, such as a county, city or town).
- Must report to HHS at least annually, but promptly if breach involves 500 or more.
- A BA must give notice to its covered entity.
- HHS publishes on its website a list of entities suffering breaches applicable to 500 or more.

HITECH Act - Breach Notification

- Content of notice to individuals:
  - dates of breach and discovery
  - description of what happened
  - description of types of information involved
  - steps individuals should take to protect themselves
  - description of covered entity’s remedial actions
  - contact information for individuals to learn more
- May need to coordinate with notice required by state law.
Administrative Simplification Penalties and Enforcement

• Civil money penalties.
• Criminal fines and imprisonment.
• Interpretation/enforcement of privacy and security rules delegated to HHS Office for Civil Rights (“OCR”).

HITECH Act - Improved Enforcement

• Enhanced civil penalties:
  • unknowing violations: $100-$50,000 per violation
  • violations due to reasonable cause: $1,000-$50,000 per violation
  • violations due to willful neglect that are corrected: $10,000-$50,000 per violation
  • violations due to willful neglect that are not corrected: min. $50,000 per violation

• All violations are subject to calendar year penalty maximums of up to $1.5 million for violations of an identical requirement.
Recent Settlements – OCR Allegations

- Health system ($3 million): Faulty server configurations allowed internet access to sensitive information of over 62,500 individuals.
- Hospital ($111,400) (Dec. 2018): Failed to remove former employees remote access to hospital’s scheduling calendar which contained PHI
- Physician group ($500,000) (Dec. 2018): No business associate agreement, did not have a policy requiring BAAs, did not conduct risk analyses, and did not implement security measures or other written policies and procedures
- Health benefits company ($16 million) (Oct. 2018): Undetected cyber attack allowing attackers to obtain almost 79 million individuals’ PHI
- Hospital ($999,000) (Sept. 2018): Unauthorized disclosure of PHI during television filming in facilities
- Health care provider ($4.3 million) (June 2018): Theft/loss of unencrypted laptop and unencrypted USB drives containing PHI of 33,500 individuals

HIPAA Compliance Areas of Focus

- Electronic security
  - Conduct risk assessment
  - Implement compliance measures mapped to security rule requirements and focused on identified risks
  - Encrypt portable devices and media
  - Implement anti-intrusion measures
- Workforce training and awareness
- Contractor diligence
- Insurance
- Incident response
HIPAA – Previews of Coming Attractions

- More cyber attacks.
- More routine OCR compliance audits.
- More OCR complaint/breach investigations, with higher dollar-value settlements.
- More private litigation:
  - Courts routinely hold that there is no private right of action under HIPAA, but
  - Affected individuals bring state law tort lawsuits using HIPAA to establish the standard of care.

OCR Website

- www.hhs.gov/ocr/hipaa/
Federal “Stark” Law

- Originally applied only to referrals for clinical laboratory services (“Stark I”).
- Expanded to apply to 10 additional categories of health services effective Jan. 1, 1995 (“Stark II”).
- CMS: The Stark law embodies a Congressional determination to discourage physicians from having financial relationships with entities to which they refer Medicare patients.
- Recent judicial decisions have applied Stark to Medicaid.

Federal Stark Law

- Unless an exception applies, the Stark Law prohibits a physician from:
  - making a referral
  - to an entity
  - for the provision of “designated health services” covered in whole or in part by Medicare (“DHS”) (has been held by courts to apply also indirectly to Medicaid)
  - when the physician (or immediate family member) has a financial relationship with the entity.
The term “referral” includes:
– request by a physician for, the ordering of or the certifying or recertifying the need for a DHS item or service; or
– establishment of a plan of care by a physician that includes the provision of DHS.

Exception to “referral” definition for services of pathologists, radiologists and radiation oncologists, when ordering a service pursuant to a consultation requested by another physician.

Federal Stark Law - DHS

- Clinical lab
- PT, OT, and speech-language pathology
- Radiology and other imaging services
- Radiation therapy services and supplies
- DME and supplies
- Parenteral/enteral nutrients, equipment and supplies
- Prosthetics, orthotics and supplies
- Home health
- Outpatient Rx drugs
- Inpatient and outpatient hospital services
Selected Entities That Provide Stark DHS

• Hospitals
• Diagnostic imaging centers
• Clinical laboratories
• Physicians and physician groups
• Pharmacies
• Home health agencies
• Physical therapy clinics

Federal Stark Law - Financial Relationships

• Ownership interests include:
  – equity (including stock, LLC memberships, partnership interests, etc.)
  – debt (including loans, bonds or other instruments secured in whole or in part with an entity's property or revenue)

• Compensation arrangements include:
  – Employment
  – Independent contractor services arrangements
  – Space/equipment leases
  – Sale/purchase transactions
  – Stock options/convertible securities
Direct and Indirect Financial Relationships

- The Stark Law applies to all *ownership* relationships – regardless of the number of links in the ownership chain.
- The same is not true for *compensation* arrangements.
  - Stark regulates direct and “indirect” compensation arrangements.
  - A direct compensation arrangement exists if there is a compensation arrangement between a referring physician and a DHS entity (like a hospital) with no intervening person or entity.
  - *Bona fide* physician owners of a physician practice “stand in the shoes” of the physician practice – removing the practice as an “intervening entity.”
  - Some relationships with intervening entities between the physician and the DHS entity are not regulated by Stark at all.

Federal Stark Law - Exceptions

- If there is a Stark-regulated financial relationship, a physician cannot refer to an entity for the provision of DHS, unless the arrangement meets all requirements of an applicable exception.
- Three categories of exceptions, as applicable to:
  - Both ownership and compensation.
  - Ownership only.
  - Compensation arrangements only.
Stark Exceptions Applicable to Both Ownership and Compensation

These include (among others):

- In-office ancillary services (key in the physician practice setting).
- Academic medical centers.
- Certain preventive screening tests.
- Eyeglasses and contact lenses following cataract surgery.
- EPO and other dialysis-related drugs.

Stark Exceptions Applicable to Ownership Only

These include:

- Publicly-traded securities.
- Mutual funds.
- Rural providers.
- Hospitals in Puerto Rico.
- Ownership in a “whole” hospital.
  - Limited by Affordable Care Act to grandfathered status.
Stark Exceptions Applicable to Compensation Arrangements Only

These include (among others):

- Rental of office space or equipment.
- Employment.
- Personal services arrangements.
- Physician recruitment.
- Certain “isolated” business transactions.
- Fair market value compensation.

Typical Compensation Arrangement Exception Requirements

- Arrangement is set forth in a writing signed by the parties.
- Compensation terms are set in advance.
- Compensation is consistent with fair market value without taking into account the volume or value of physician referrals to the entity.
- Arrangement is commercially reasonable in the absence of physician referrals to the entity.
Key Prohibitions and Sanctions

• Physician cannot make a DHS referral to an entity with which the physician has a prohibited financial relationship.

• The entity cannot bill for DHS provided pursuant to a prohibited referral.

• Civil money penalty of up to $15,000 per service for presenting or causing to be presented a claim that the person knows or should know is prohibited.

• Potential for exclusion from government health care programs.

Stark Issues and Risks – Generally

• Must satisfy all elements of an applicable exception.

• Strict liability – intent not relevant.

• Potential for “technical” violations.

• Financial consequences can be drastic.

• Stark violations are a natural predicate for federal False Claims Act (“FCA”) actions.

• Current FCA challenges are focused on fair market value and commercial reasonableness of physician compensation.

• Remember the federal anti-kickback statute and state law.

- Newly promulgated exceptions:
  - Timeshare arrangements
  - Assistance for recruitment of non-physician practitioners
- Revised exceptions/guidance:
  - Retention payments to physicians in underserved areas
  - Geographic area for physician recruitment by FQHCs and RHCs
  - Ownership of publicly traded securities
  - Physician ownership of hospitals
- Reform? – Revisions and clarifications regarding:
  - Writing requirements
  - Term requirements
  - Holdover arrangements
  - Temporary noncompliance with signature requirements
  - Remuneration

Stark: Final Considerations

- Enforcement will only increase
  - Government enforcement authorities
  - Whistleblowers
  - Increasing risk of individual liability
- CMS voluntary disclosure protocol
- Prospects for further reform?
  - Senate Finance/House Ways & Means Committee initiative
    - “Why Stark, Why Now?” – A Senate Finance Committee Majority Staff Report (June 30, 2016)
    - CMS Request for Information (June 2018)
In order to meet “meaningful use” requirements, ABC Hospital has established an online patient portal to allow patients to remotely access the patient’s medical information stored in the hospital’s electronic health record. ABC Hospital’s IT department has installed a variety of technical measures to protect against unauthorized access to the EHR and is constantly monitoring for any indication of a compromise to the EHR.

Early one morning, the Hospital’s intrusion detection system records a potential unauthorized intrusion event that triggers an e-mail alert to ABC Hospital’s Chief Information Officer. The CIO gathers the IT staff to investigate. Within 12 hours of the alert, the IT staff has found forensic evidence indicating that an unauthorized person using compromised access credentials for a Hospital employee appears to have had access to over 1,000 patient records, including both detailed health information and social security numbers.

The CIO contacts ABC Hospital’s Chief Compliance Officer who also serves as the Hospital’s Chief Privacy Officer. The Chief Privacy Officer in turn contacts the General Counsel, and the three meet to discuss the potential breach situation. The CIO reports the facts described above. The Chief Privacy Officer and General Counsel agree to initiate the breach notification process by identifying the affected individuals, organizing contact information and preparing a draft notification letter.

The General Counsel and Chief Privacy Officer contact the CEO to brief her on the emerging situation. The Chief Privacy Officer goes over the requirements of the HIPAA breach notification rule, including the presumption of breach, the risk assessment factors and the obligation to furnish notice to individuals without unreasonable delay. The Chief Privacy Officer also advises the CEO that because more than 500 individuals may have been affected, ABC Hospital also will be required to notify prominent media outlets regarding the breach.

“This is a disaster,” says the CEO. “We do NOT need this kind of publicity. Do we know for sure that this hacker was able to download the information? And even if he did, do we know for sure that he’s going to disclose it to anybody else or use it for identity theft? It could be one of those geeks who do this for kicks just because they can, but without intending to harm anybody.”

“I think we need to get the notices out right away,” says the Chief Privacy Officer. “The risk is just too high. We’ll have the letters ready to go by the end of the day tomorrow, and we just can’t wait.”

The CEO turns to the General Counsel. “I want to give this a few days to see if we can get a better handle on what happened. Isn’t there some way we can investigate this, do a forensic analysis, or something? This is going to hurt us badly in the marketplace, and I don’t want to go public on this until we absolutely have to.”

(Discussion Points next page)
Discussion Points:

1. As the general counsel, your privacy officer says that breach notifications have to be sent out immediately, but your CEO is directing you to hold off pending an investigation. What do you do?

2. You conclude that there is a reasonable basis to delay notification pending an investigation. You attended a CLE and remember that an Assistant U.S. Attorney and FBI Special Agent who specialize in cybercrime issues spoke on a panel. You have their contact information and decide to call them to report the incident.

3. You have enlisted the support of the FBI and the U.S. Attorney’s Office to help investigate the suspected hacking incident, but several days have passed. The privacy officer comes by your office several times a day, checking on status, and urging you to authorize sending of the breach notifications. About 3 days in, during a status report meeting with the CEO, CIO and privacy officer, the privacy officer blurts out: “That’s it. We’ve waited too long. I can’t tolerate this anymore. Either the notices go out by the end of the day tomorrow or I’m calling the OCR and the media myself!” The privacy officer storms out.

   The CEO says: “You know, he’s not really a team player. And he’s not very good in a crisis. Can we fire him?” she asks.

4. After a week passes, you are starting to find yourself aligned with the privacy officer. You call the Assistant U.S. Attorney and let him know that unfortunately you will be needing to get notifications out asap. The AUSA asks you to delay notifications because the AUSA believes that notifications would impede the investigation.

5. You end up delaying notifications at the request of the U.S. Attorney’s office based on the U.S. Attorney’s view that notifications would impede a criminal investigation. Another week passes. Then, you get a call from the Assistant U.S. Attorney. The hacker has been identified, and he’s a member of known identity theft ring. You inform the CEO that it’s now unequivocally time to make the HIPAA required breach notifications. The CEO still refuses to follow your legal advice. How should you proceed?
Potentially Applicable Georgia Rules of Professional Conduct:

Rule 1.2 Scope of Representation and Allocation of Authority Between Client and Lawyer.

Rule 1.6 Confidentiality of Information.

Rule 1.13 Organization as Client.

Rule 1.16 Declining or Terminating Representation.

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I. Introduction: Medicare and Medicaid

Medicare and Medicaid affect nearly all aspects of the health care delivery system in the United States. Combined, the two programs provide health care coverage for over 130 million Americans enrolled for calendar year 2018. See CMS Fast Facts Program Data-Population (July 2018). Medicare and Medicaid are government funded health insurance programs created by amendments to the Social Security Act (“SSA” or the “Act”) in 1965 to increase access to medical services for the elderly and poor who were not receiving basic medical care.

The Medicare program is fully funded by the federal government and provides health care coverage for individuals over the age of 65, individuals under the age of 65 with certain disabilities and individuals with end-stage renal disease (“ESRD”). Eligibility for Medicare does not take into consideration income or financial resources.

The Medicaid program is jointly funded by federal and state governments and primarily serves low-income children, parents, the elderly and individuals with disabilities. Regulation places stringent income and resource limits on eligibility for most Medicaid programs. In 1997, Congress created the Children’s Health Insurance Program (“CHIP”) to provide health insurance for children who were ineligible for the Medicaid program and still uninsured.

The Medicare Program

Administered by the Centers for Medicare and Medicaid Services (“CMS”) under the operations of the U.S. Department of Health and Human Services (“HHS”), Medicare is composed of four parts: Parts A, B, C and D, that together offer beneficiaries a full range of health care services.

A. Medicare Eligibility and Benefits

1. Medicare Part A

   a. Eligibility

   Eligibility for Medicare Part A is generally attained by satisfying the criteria for Social Security benefits eligibility, as a result of age or disability, or an ESRD diagnosis. 42 C.F.R. § 406.5. An individual is eligible for Social Security retirement benefits after reaching the age of 62 and accumulating a total of 40 work credits, which according to
the Social Security Administration is equivalent to approximately 10 years of work. See Social Security Retirement Benefits, Social Security Administration, at 1 (2019), available at https://www.ssa.gov/pubs/EN-05-10035.pdf. Federal, state and local government employees who are age 65 and older may also be eligible for Medicare provided that the individual’s employment was not limited to work as a temporary employee, prison inmate, intern or student worker or an election worker. 42 U.S.C. § 426(a); 42 C.F.R § 406.15. In addition, individuals who have lived in the United States for five years and have reached the age of 65 can obtain Medicare Part A benefits by paying a premium. 42 C.F.R. §§ 406.5, 406.20.

Individuals under the age of 65 who have a permanent disability can also obtain Part A benefits. For individuals with ESRD or those with amyotrophic lateral sclerosis (“ALS” or “Lou Gehrig’s Disease”), benefits are available immediately upon diagnosis. 42 C.F.R. § 406.5; see also Medicare at a Glance at 1, available at https://kaiserfamilyfoundation.files.wordpress.com/2013/03/7067-02_medicare-at-a-glance.pdf (accessed Jan. 9, 2019). Other permanently disabled individuals are not eligible until after receipt of disability benefits under Social Security or receipt of benefits under the Railroad Retirement program for 25 consecutive months. 42 C.F.R. § 406.5.

b. Benefits


Inpatient hospital care is treatment provided in any hospital including “specialty” hospitals, such as orthopedic hospitals and heart hospitals, as well as those that provide more global services, such as acute care hospitals, long-term hospitals, critical care hospitals and psychiatric hospitals. See 42 U.S.C. § 1395e(a)(1), (3); Alexander at 19. Medicare coverage for inpatient care is limited to 90 days per benefit period. 42 C.F.R. § 409.61. “Benefit period” is defined as the period beginning upon admission to an inpatient hospital stay or SNF and ending when the inpatient stay has ceased for 60 days in a row. Beneficiaries are responsible for a deductible and coinsurance for any days after 60 days of admission, and beneficiaries incur larger deductible and coinsurance payments if the admission lasts more than 90 days. Id. Beneficiaries have 60 lifetime reserve days in which Medicare will pay for all covered services except the daily coinsurance. 42 C.F.R. § 409.61(a)(2).

For beneficiaries needing skilled nursing care, Part A covers 100 days per benefit period, if the beneficiary was admitted to the hospital as an inpatient for at least three consecutive calendar days within 30 days of admission to the SNF. 42 C.F.R. § 409.61(b).
In regards to home health, Part A covers eligible services with no deductible, but subject to durable medical equipment (“DME”) payment limitations. 42 C.F.R. § 409.61(d). Eligibility for home health also requires that the patient’s physician certify the need for one or more of the following: intermittent skilled nursing care, physical therapy, or speech language therapy, continuing physical therapy or occupational therapy.

Terminally ill beneficiaries are eligible for hospice services for two 90-day periods followed by unlimited 60-day periods. See 42 C.F.R. § 418.21. The hospice provider must obtain written certification of terminal illness for each benefit period. 42 C.F.R. § 418.22. To qualify for coverage, (1) the beneficiary is required to file a hospice election statement that identifies the hospice that will provide care to the individual; (2) an acknowledgement from the individual or the individual’s representative that states that the individual understands that coverage for services related to treatment of the terminal condition has been waived; and (3) effective and end dates for the hospice election. 42 C.F.R. § 418.24. The services available under a hospice election include nursing care, medical social services, physicians’ services, counseling services, home health aide, medical appliances and supplies, and physical and occupational therapy. 42 C.F.R. § 418.

2. Medicare Part B

a. Eligibility

Medicare Part B is voluntary coverage that requires the payment of a monthly premium. Medicare Part A beneficiaries are automatically enrolled in Part B unless they specifically decline coverage. 42 C.F.R. § 407.10; Alexander, at 96. Individuals age 65 and older who are not eligible for Part A can also obtain benefits under Part B by paying a premium. 42 C.F.R. § 407.10 (a)(2); Alexander, at 96. In addition, all Part B beneficiaries are required to pay deductibles and coinsurance. The federal government pays 80% of the fee schedule amount and the beneficiary pays the remaining 20% after the annual deductible has been satisfied. Part B Medicare Insurance: What You Pay, NOLO, available at https://www.nolo.com/legal-encyclopedia/part-b-medical-insurance-what-you-pay.html (accessed Jan. 18, 2019). The following services are not subject to a deductible: home health services, clinical diagnostic laboratory services, fecal occult blood tests, pneumonia and flu vaccines, kidney donation, and services provided in a Federally Qualified Health Center (“FQHC”). Alexander, at 43.

b. Benefits

Medicare Part B provides “medical and other healthcare services.” 42 U.S.C. § 1295j-k; Alexander, at 100. These services include treatments personally performed by a medical doctors or doctors of osteopathy, dentists, optometrists, podiatrists and chiropractors, under limited circumstances. See 42 U.S.C. §§ 1395d(a)(3), 1395k(a)(2)(A), 1295x(r); Alexander, at 44. Part B also covers professional services provided by non-physician practitioners ("NPP") including therapists, clinical psychologists, licensed clinical social workers, certified nurse midwives, certified
registered nurse anesthetists, physician assistants, nurse practitioners, clinical nurse specialists and audiologists, provided that the services are performed “incident to” the physician’s services. See 42 C.F.R. §§ 410.26; 414.34; Medicare Benefit Policy Manual, Ch. 15, § 50; Alexander, at 45. “Incident to” services are services that are considered an essential element of the physician’s professional services and are furnished under one of the following conditions (1) in a non-institutional setting when services are limited to non-institutional patients; (2) to a patient in a physician’s office; (3) in any setting under the physician’s direct supervision; or (4) by employees, leased employees or independent contractors of a health care facility. Id. Beginning in 2015, CMS allowed greater flexibility for clinical staff performing duties that were “incident to” chronic care management services. See 42 C.F.R. § 410.26. Diagnostic tests including x-ray, EKG, mammogram, and sleep studies are also included as Part B Services. See 42 C.F.R. § 410.32; Alexander, at 46.

3. Medicare Part C

c. Eligibility

Medicare Part C, the Medicare Advantage Program ("Medicare Advantage"), provides health care coverage under a managed care benefits plan. See 42 C.F.R. § 422.50; Alexander, at 73-74. Part C eligibility requires the beneficiary to be eligible for Part A and enrolled in Part B. ESRD beneficiaries are not eligible for most Part C plans. 42 C.F.R., § 422.52; Alexander, at 72.

d. Benefits

Medicare Advantage plans are required to offer all services covered by Part A and Part B, excluding hospice, that are available within the plan’s service area. What’s a Medicare Advantage Plan?, CMS (April 2015), at 2, available at: https://www.medicare.gov/Pubs/pdf/11474.pdf (accessed Jan. 18, 2019). Depending on the plan, Medicare Part D prescription drug coverage may be also required. 42 C.F.R. §§ 422.100, 422.101, 422.102; Alexander, at 74. Plan administrators are given broad discretion with regards to determining which, if any, additional services will be covered. 42 C.F.R. § 422.102; Alexander, at 72.

The four basic categories of plans offered under Medicare Advantage are: (1) coordinated care plans, (2) private fee-for service plans, (3) medical savings account plans, and (4) religious fraternal benefit plans. 42 C.F.R. § 422.4; Alexander, at 69.

Coordinated care plans are benefits packages provided through a network of contracted providers. 42 C.F.R. § 422.112. Coordinated care plans are required to offer at least one benefits package that includes Part D benefits. 42 C.F.R. § 422.112; Alexander, at 70, 74. Religious fraternal benefit plans are a form of a coordinated care plan, but these plan administrators have discretion to decide whether Part D coverage will be included in benefits packages. Id.
Private fee-for-service plans pay providers on a fee-for-service basis and provide beneficiaries with a network of providers willing to treat beneficiaries enrolled in the plan. 42 C.F.R. § 422.114; Alexander, at 71. Fee-for-service plans have discretion to decide whether to include Part D coverage in benefits packages. 42 C.F.R. § 422.114; Alexander, at 74. Medicare Advantage Plans may also offer medical savings account plans. These high deductible plans include a medical savings account funded by CMS. Fact Sheet on Medicare Medical Savings Account (MSA) Plans, CMS, available at: https://www.cms.gov/Medicare/Health-Plans/MSA/downloads/MSAFactSheet-3-13-08.pdf (accessed Jan. 18, 2019); Medicare and Medicare and You, CMS, 55 (2019) available at https://www.medicare.gov/pubs/pdf/10050-Medicare-and-You.pdf (accessed Jan. 12, 2019). CMS pays the premium and beneficiaries are permitted to use account funds to pay for covered services until the deductible is reached. See Medicare, Medicare Medical Savings Account (MSA) Plans, available at https://www.medicare.gov/sign-up-change-plans/types-of-medicare-health-plans/medicare-medical-savings-account-msa-plans (accessed Jan. 12, 2019). Once the deductible has been satisfied, the plan pays 100% of covered services. Id. Savings account plans are not permitted to offer Part D coverage. Id.

4. Medicare Part D

Medicare beneficiaries who are entitled to benefits under Medicare Part A or enrolled in Part B are eligible to enroll in Part D. 42 C.F.R. § 423.30. Medicare Part D is voluntary and requires beneficiaries to participate in cost sharing. Alexander, at 97. Beneficiaries must join a plan and pay co-pays and premiums in exchange for prescription drug benefits. See Id. at 86. Medicare Part D is offered through private payors that contract with CMS. Id. As discussed above in regards to Part C, Part D can be included as part of a Medicare Advantage plan; however, Part D benefits are also available as stand-alone plans. See Medicare at a Glance at 1. Beneficiaries have the opportunity to enroll in Part D annually during a specified timeframe, which occurs from October 15 through December 7. Understanding Medicare Part C and Part D Enrollment Periods, CMS, 5 (Oct. 2018), available at https://www.medicare.gov/Pubs/pdf/11219-Understanding-Medicare-Part-C-D.pdf. Beneficiaries may owe a late enrollment penalty if, at any time after their initial enrollment period ends, they do not have Part D or other creditable prescription drug coverage for a period of 63 or more days in a row. Medicare Part D Late Enrollment Penalty, Medicare.Gov, available at http://www.medicare.gov/part-d/costs/penalty/part-d-late-enrollment- penalty.html (accessed Jan. 12, 2019). The late enrollment penalty is calculated by multiplying 1% of the “national base beneficiary premium” ($33.19 in 2019) times the number of full, uncovered months a beneficiary was eligible but did not join a Medicare Prescription Drug Plan and went without other creditable prescription drug coverage. Id.

e. Benefits

For a prescription drug to be covered under Part D, the drug must be (1) available only by prescription, (2) approved by the Food and Drug Administration (FDA), (3) used and sold in the United States, and (4) prescribed for a medically accepted
indication. See 42 C.F.R. § 423.100; Medicare Part D Manual, Chap. 6, §§ 10.1, 10.6, 10.7. Part D generally does not cover drugs that may be excluded under Medicaid or certain drugs that are covered under Medicare Part A or B. Medicare Part D Manual at § 20.2. The following are excluded from Medicare coverage: drugs for anorexia, weight loss, or weight gain; drugs used to promote fertility; drugs used for cosmetic purposes or hair growth; drugs used for the symptomatic relief of cough and colds; prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations; nonprescription drugs; outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale; barbiturates; benzodiazepines; and agents used for the treatment of sexual or erectile dysfunction except under certain conditions. Medicare Part D Manual at § 20.1.

B. The Medicare-Provider Relationship

1. Enrollment and Conditions of Participation

Enrollment in Medicare requires providers to complete and submit the appropriate enrollment application and sign a statement of participation whereby the provider agrees to comply with the Medicare conditions of participation. Most providers can enroll through the Internet-based Provider Enrollment, Chain and Ownership System (“PECOS”). Providers may also enroll through the paper enrollment process by filing the appropriate CMS 855 form.

Prior to enrollment, a provider must have a National Provider Identifier (“NPI”), which replaced other provider identifiers used in health care transactions. Providers obtain a NPI through National Plan and Provider Enumeration System (“NPPES”).

Institutional providers, including hospitals, outpatient physical therapy, occupational therapy and speech pathology services’ FQHCs, hospices, rural health clinics (“RHCs”), ESRD facilities, home health agencies, community mental health centers, and comprehensive outpatient rehabilitation facilities enroll using an 855A Form. Other types of non-institutional providers, including physician group practices/clinics, independent diagnostic testing facilities and ambulatory surgery centers, are required to complete an 855B Form. Individual physicians and non-physician practitioners such as nurse practitioners and physician assistants who are enrolling in Medicare for the first time must submit an 855I Form. DME suppliers must submit an 855S Form. Physicians and other NPPs use the CMS form 855R to reassign Medicare benefits/receivables of the enrolled physician or other non-physician practitioner to his or her group practice or other employer. Providers and suppliers who do not wish to enroll in Medicare, but who order and refer Medicare reimbursed services must complete an 855O application.

The Affordable Care Act of 2010 (“ACA”) required CMS to establish new screening procedures for Medicare enrollment, including a licensure check. 42 U.S.C. § 1395cc(j). The statute allows CMS to include any or all of the following additional screening measures: criminal background checks; fingerprinting; unscheduled,
unannounced or pre-enrollment site visits; database checks; and other screening that the Secretary of HHS may determine to be necessary or appropriate. *Id.* at § 1395cc(j)(2)(B).

Providers must report changes in practice location and ownership (including changes in delegated and authorized officials) and final adverse actions within 30 days of the change.  42 C.F.R. § 424.516(d). All other changes must be reported within 90 days of the event.  42 C.F.R. § 424.516(e). It is important that providers regularly update their enrollment with their Medicare contractor.

For a health care facility to enroll and participate in Medicare for reimbursement under Medicare Part A, the provider must satisfy the Medicare conditions of participation (“CoPs”). CoPs set standards for the corporate governance of the facility and its medical staff and clinical operations. CoPs also address patient rights, quality assurance, infection control, and medical records management. See “Conditions for Coverage and Conditions of Participation”, CMS.gov, available at https://www.cms.gov/CFCsAndCoPs/ (accessed Jan. 12, 2019); Alexander, at 23.


“Participation” in Medicare means that the provider agrees to accept assignment of all claims for all services he or she furnishes to Medicare beneficiaries. The provider agrees to accept Medicare-allowed amounts as payment in full and will not collect more than the allowed Medicare allowed deductible and coinsurance from Medicare beneficiaries. If a provider decides to be a “participating” physician he or she completes the CMS Form 460 during the initial enrollment process or enrollment period. The benefits to participating include a reimbursement 5% higher than those who do not participate; payments are issued directly to the provider; and claim information is forwarded to Medicare supplemental coverage insurers. Despite certain advantages, some providers elect not to participate in Medicare because reimbursement rates can be lower than for private insurance and Medicare coverage rules are complex, detailed, and subject to change.

It is also important to note that suppliers enrolled as non-participating are subject to “limiting charges” imposed by CMS, and physicians are able to “opt out” of Medicare under two-year contracts. [insert]
2. Revalidation

CMS regulation now requires most providers to update their enrollment information at least every five years through a process called revalidation. See CMS, Revalidations, https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Revalidations.html (accessed Jan. 12, 2019). Revalidation applies to providers and suppliers that were enrolled prior to March 25, 2011. CMS regulations require this revalidation every five years and also reserve the right to perform “off-cycle” revalidations and site visits. 42 C.F.R. § 424.515 (2016). Providers and suppliers have 60 days from the post mark date of the revalidation letter from CMS to submit the required completed enrollment forms. CMS, Sample Revalidation Letter, available at http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/SampleRevalidationLetter.pdf (accessed Jan. 12, 2019). Providers and suppliers can submit their revalidation form online through the Internet-based PECOS or through a paper application form.

The revalidation process can be cumbersome, but the deadlines for revalidation are rigid and the consequences for non-compliance can be severe. Failure to submit enrollment forms as requested may result in the deactivation of Medicare billing privileges. See Vizy and Weinberger vs. Centers for Medicare and Medicaid Services, Docket Nos. C-16-367 and C-16-368 (June 24, 2016) (upholding a CMS decision that two providers who failed to revalidate timely were not eligible to have their billing privileges retroactively dated to the original revalidation deadline, resulting in almost 6 months in lost billing privileges).

3. Provider Payment: Conditions of Payment

To receive payment for services, providers must comply with the Medicare conditions for payment. 42 C.F.R. § 424.32 (2016). These conditions require claims to be submitted on the proper form using the appropriate diagnostic coding. Id. There are six basic conditions for payment: (1) the services must be covered services or excluded but otherwise reimbursable services (as determined by regulation); (2) the services were provided by a qualified provider or supplier; (3) the services were rendered while the individual was eligible to have payment made for them; (4) the provider obtained certification that the services were needed (if required); (5) the provider, supplier, or beneficiary (as appropriate) filed a claim that include a reference to a request for payment; and (6) the provider, supplier, or beneficiary (as appropriate) furnishes sufficient information to determine whether payment is due and the amount of payment. Id. at § 424.5(a) (2016).

The claim must be signed by the beneficiary or on the beneficiary’s behalf and be filed within one full calendar year following the year in which the services were provided. Understanding Claims: How to File a Claim, available at http://www.medicare.gov/claims-and-appeals/file-a-claim/file-a-claim.html (accessed Jan. 12, 2019). Providers are generally required to file claims electronically with very limited exceptions. 42 C.F.R. § 424.32 (2016). Providers that submit too many paper
claims may be subject to enforcement review to determine if an exception is met. See Medicare Claims Processing Manual (Pub. 100-4), Chap. 24, § 90.5.

C. Penalties for Non-Compliance

Providers can suffer civil and criminal penalties for Medicare non-compliance, in addition to the revocation of their enrollment and exclusion from the program. Penalties can stem from both intentional fraud and provider negligence. Some examples of activities that can trigger civil or criminal penalties for Medicare non-compliance include: inappropriately trying to increase utilization of care (in violation of the Anti-Kickback Statute and the Stark Law), waiving Medicare patient copays and deductibles, offering remuneration to an individual who is eligible for Medicare or Medicaid to influence the individual’s health care choices, upcoding and other billing and payment fraud, and failing to disclose overpayments. Medicare Fraud & Abuse: Prevention, Detection, and Reporting, CMS, 2–3, available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Fraud_and_Abuse.pdf (accessed Jan. 12, 2019).

CMS has several programs in place to combat these types of abuses and non-compliance. These programs help prevent improper payments before a claim is processed and to identify and recoup improper payments after the claim is processed. The programs include the National Correct Coding Initiative, the Medical Unlikely Edits Program, the Medical Review Program, the Comprehensive Error Rate Testing Program, the Quality Improvement Organization review program, the Recovery Audit Program, and the Medical Review Program. Medicare Claim Review Programs: MR, NCCI Edits, MUEs, CERT, and Recovery Audit Program, GARNER HEALTH, available at http://garnerhealth.com/wp-content/uploads/2014/02/MCRP_Booklet.pdf (accessed Jan. 12, 2019).

The False Claims Act (“FCA”) also provides the federal government with a powerful tool to combat Medicare non-compliance. The FCA imposes penalties on individuals or provider entities that knowingly submit false or fraudulent claims for payment to the government. 31 U.S.C. § 3729(a)(1)(A). The Justice Department can file an FCA action, but so can a qui tam relator who acts as a fraud whistleblower and brings the case on the government’s behalf. Id. at § 3730(a)–(b) FCA cases and settlements for reimbursement-related violations can result in huge monetary penalties because of the large number of Medicare reimbursement requests covered entities file and the ability of FCA plaintiffs to seek treble damages and attorney’s fees. Id. at §§ 3729(a)(1)(G), 3729(a)(3).

The HHS Departmental Appeals Board (“DAB”) and Civil Remedies Division (“CRD”) oversee CMS’s revocation decisions through an appeal process.1 These two review departments release a number of opinions upholding CMS’s revocation decisions.

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1 DAB and CRD publish their opinions at www.hhs.gov/dab/decisions/dabdecisions/index.html and www.hhs.gov/dab/decisions/civildecisions/index.html, respectively.
and in some instances issue opinions overturning CMS’s decision. Some examples of these decisions are highlighted below:

- **DAB upheld the revocation of a home health agency’s provider number finding that the agency was not open to the public and “operational to furnish Medicare covered services” as required by 42 C.F.R § 424.510(d)(6). The agency’s doors were locked and no one responded when a site inspector visited.** Docket No. A-16-145, Decision No. 2778 (App. Div.) (March 30, 2017)

- **DAB upheld the revocation of a DMEPOS supplier’s enrollment and billing privileges for failure to maintain accreditation. While the DMEPOS supplier was accredited at the time of the appeal, its accreditation had lapsed for 7 months while it was in the process of changing accrediting agencies.** Docket No. A-16-123, Decision No. 2766 (January 25, 2017).

- **DAB upheld a CMS decision to revoke a provider’s Medicare enrollment for two years where she failed to include an explanation of license revocation in her individual Medicare revalidation application.** Docket No. C-16-443, Decision No. CR4664 (July 26, 2016).

- **DAB upheld a CMS decision to revoke a provider’s enrollment for three years because he failed to accurate report his practice location during revalidation and CMS uncovered the “mistake” during an attempted site visits.** Docket No. C-15-3863, Decision No. 4511 (January 20, 2016).

- **DAB upheld a CMS decision to revoke an orthopedic surgeon’s Medicare enrollment where the provider’s Medicaid billing privileges were terminated or revoked.** Docket No. A-15-64, Decision No. 2663 (October 27, 2015).

- **DAB upheld a CMS decision to revoke a physician’s enrollment for abuse of billing privileges because the physician billed more services than can possibly be provided during a given time period.** Docket No. A-14-84, Decision No. 2592 (September 15, 2014).

- **CRD upheld a CMS decision to revoke a home health provider’s enrollment for failing to report a change to its business address within 90 days. CRD also held that CMS did not have to accept a Plan of Correction from the provider and that CMS’s refusal to accept the plan is not reviewable.** Docket No. C-14-691, Decision No. 3305 (July 22, 2014).
II. The Medicaid Program

All 50 states, the District of Columbia and United States territories have established Medicaid programs. *Federal Core Requirements and State Options in Medicaid: Current Policies and Key Issues*, Kaiser Commission on Medicaid and the Uninsured, April 2011. To receive federal funding for its Medicaid program, a state must designate a single state agency for administration of the program and devise a state plan that describes the administration of the program, individual eligibility, covered services, and reimbursement methodologies. 42 U.S.C. § 1902; Craig H. Smith, *Fundamentals of Medicaid*, AHLA Fundamentals of Health Law, November 13-115, 2011 at 5. The availability of federal funds for Medicaid benefits is further conditioned on a state’s compliance with its state plan. *See* 42 U.S.C. § 1396c. CMS must approve the state plan, amendments, waivers and significant changes to a State’s Medicaid program. *Id.* at 4-5.

A. Medicaid Eligibility and Benefits

1. Mandatory Eligibility and Covered Services

The SSA requires a state to provide to “all individuals wishing to make an application for medical assistance” the opportunity to do so. Smith, at 8; *see* 42 U.S.C. § 1396a(a)(8). The state must make an eligibility determination “with reasonable promptness” and provide the decision to the applicant in writing. *Id.* Denial letters must include the reason for the denial and the specific regulation supporting the determination. 42 C.F.R. § 435.912. The SSA affords applicants a right to a hearing if their application is denied or if the state fails to make a timely eligibility determination 42 U.S.C. § 1396a(a)(3). Coverage for services can be made retroactive for three months prior to the month in which the individual submitted an application to the state Medicaid agency, provided that the individual was eligible for assistance during the retroactive time period. 42 U.S.C. § 1396a(a)(34).

a. Mandatory Eligibility

All states are required to provide medical assistance to five core groups of low-income, “mandatory categorically needy” individuals, which includes (1) pregnant women, (2) children, (3) parents, (4) the elderly, and (5) individuals with disabilities. *Federal Core Requirements* at 4. The federal poverty level (“FPL”) is used to determine economic eligibility for coverage. In 2018, the FPL for a family of four is $25,100 per year. Federal Poverty Level, available at [https://www.healthcare.gov/glossary/federal-poverty-level-fpl](https://www.healthcare.gov/glossary/federal-poverty-level-fpl) (accessed Feb. 14, 2019). In states the expanded Medicaid under the Affordable Care Act, the minimum income is 138% of the FPL. In states that did not expand Medicaid, the minimum income is 100% of the FPL. *Id.*

Aged, blind, and disabled individuals receiving or deemed eligible for receipt of Social Security Income can receive Medicaid coverage. 42 U.S.C. § 1396a(a)(10); Smith at. 9. Parents who would have qualified for Aid to Families with Dependent Children (“AFDC”), or Temporary Assistance to Needy Families (“GANF”) are also eligible, but
beneficiaries qualifying under this option are required to have significantly lower incomes than other Medicaid beneficiaries. *Id.* In most states, to qualify for Medicaid as a parent, a beneficiary must have an income of less than 50% FPL. *Smith* at 9; *Federal Core Requirements* at 4. Under the ACA, states would have been required to expand Medicaid eligibility across all core groups to 133% FPL and to include non-disabled adults without dependent children, who have historically been excluded from Medicaid eligibility. *Federal Core Requirements* at 4. However, in *National Federation of Independent Business v. Sebelius*, 132 S.Ct. 2566 (2012), the Supreme Court held the Medicaid Expansion unconstitutional. As a result, individual states have discretion to decide whether to adopt the ACA Medicaid expansion. As of January 2019, 32 states and the District of Columbia have adopted some form of Medicaid expansion. Current Status of State Medicaid Expansion Decisions, available at [https://www.kff.org/health-reform/slide/current-status-of-the-medicaid-expansion-decision/](https://www.kff.org/health-reform/slide/current-status-of-the-medicaid-expansion-decision/) (accessed Jan. 12, 2019).

b. Mandatory Benefits

Due to the diversity of the needs of Medicaid beneficiaries, Medicaid benefits are fairly broad in scope. *Medicaid a Primer* 2010, The Kaiser Commission on Medicaid and the Uninsured at 14. Figure 1 below identifies mandatory services.

![Figure 1: Mandatory Covered Services for Categorically Needy Beneficiaries](image)

While states have no discretion whether to cover mandatory services for categorically needy beneficiaries, states are authorized to determine the amount, duration and scope of benefits offered under the Medicaid program. 42 C.F.R. § 440.230. The SSA further authorizes states to place utilization controls and medical
necessity requirements on covered benefits. *Id.* This discretion is limited only by the stipulation that a restriction on a benefit cannot render the benefit insufficient to “achieve its purpose.” 42 U.S.C. § 1396a(a)(10)(B).

2. Optional Eligibility and Benefits

a. Optional Eligibility

Currently, no state’s Medicaid program eligibility is limited to mandatory categorically needy beneficiaries with benefits coverage restricted to mandatory services. Federal Core Requirements at 5 & 7. Most states have expanded eligibility for children and pregnant women. [http://kff.org/medicaid/fact-sheet/where-are-states-today-medicaid-and-chip/](http://kff.org/medicaid/fact-sheet/where-are-states-today-medicaid-and-chip/) (accessed Jan. 12, 2019). Every state has also expanded the scope of Medicaid services to include prescription drug coverage, but other optional benefits available vary widely from state to state. *Federal Core Requirements* at 7.

b. Optional Benefits

States are somewhat limited in their ability to expand the eligibility pool for Medicaid beneficiaries without applying for a waiver, waiver-like provision or amending the state plan. Smith, at 28. Thus, states frequently expand eligibility based only on income measures. “Optional categorically needy” beneficiaries are generally considered low-income individuals, but their income and resource level exceed the limits set forth for mandatory categorically needy coverage. 42 U.S.C. § 1396a(a)(10)(A)(ii). Individual states determine the income and resource limits for eligibility as an optional categorically needy beneficiary. 42 U.S.C. § 1396a(a)(10)(A)(ii). A state has broad discretion to determine which additional optional services will be available to beneficiaries in the state. *Id.* Listed in Figure 2 are the benefits that a state can select.

Generally, a state must ensure that identical benefits coverage is available to medically needy and categorically needy beneficiaries, respectively. 42 U.S.C. § 1396a(a)(10)(B)-(C); 42 C.F.R. § 440.240. Benefits must also be made available on a state-wide basis. 42 U.S.C. § 1396a(a)(1).

The “medically needy” are unique among Medicaid beneficiaries, because their eligibility takes into account more than income and resources alone. 42 C.F.R. § 435.300. For an individual to be eligible as “medically needy,” the individual’s income level must be considered equivalent to an amount at or below the medically needy level for the state as established by the state under its state plan. 42 C.F.R. § 301.301(1)(i). The SSA, however, allows income and resource levels to be offset by medical expenses. 42 U.S.C. §§ 1396a(a)(10)(C)(i), 1396a(a)(17); 42 C.F.R. §§ 435.301, 435.811, 435.1097. Thus, if a medically needy individual has an income that exceeds the state’s preset maximum income level, the income and resources of the beneficiary are combined with debt. 42 C.F.R. § 435.301; Smith at 10. If medical debt subtracted from the individual’s income and resource levels is less than the requisite amount for eligibility as a medically needy beneficiary, the individual is deemed eligible for Medicaid coverage. *Id.*
As stated above, the services available to beneficiaries can vary widely from state to state. However, if a state elects to extend eligibility to medically needy beneficiaries, the services listed in Figure 3 become mandatory for such beneficiaries. 42 U.S.C. § 1396a(a)(10); 42 C.F.R. §§ 440.225; https://www.medicaid.gov/medicaid/benefits/list-of-benefits/

The primary exceptions to benefit coverage rules are benchmark and benchmark equivalent plans, waivers and demonstration projects. The Deficit Reduction Act (“DRA”) of 2005 contained a provision that amended the SSA to allow states to vary the Medicaid benefit package available to Medicaid beneficiaries by using benchmark and benchmark equivalent plans. See Deficit Reduction Act Important Facts for State Policymakers, CMS, Feb. 2008. A state must amend its state plan to offer services using benchmark or equivalent plans. Smith, at 27-28.
Benchmark plans allow states to limit benefits to coverage that is standard in the (1) Blue Cross Blue Shield preferred provider option under the Federal Employee Health Benefits Plan, (2) the HMO plan with the largest commercial, non-Medicaid enrollment in the state, (3) any generally available state employee plan, or (4) any plan that the Secretary of HHS deems appropriate. 42 U.S.C. § 1396u-7; Smith, at 27-28. Benchmark equivalent plans must minimally cover inpatient and outpatient hospital services, physician surgical and medical services, lab and x-ray services, well-baby and well-child care and other appropriate preventative services as designated by HHS. Smith, at 27-28. In addition, states must ensure that children under the age of 21 have access to Early and Periodic Screening Diagnostic and Treatment (“EPSDT”) services and access to FQHC services either under the benchmark plan or equivalent, or via some other means. 42 C.F.R. § 440.345; Smith, at 27-28. EPSDT coverage includes coverage for screening, preventive and early intervention services as well as diagnostic services and treatment necessary to correct or ameliorate a child’s physical or mental condition. Medicaid a Primer, 2010, The Kaiser Commission on Medicaid and the Uninsured, at 14. This coverage is often more inclusive than what beneficiaries under private insurance plans can obtain. Id.

States are permitted to mandate beneficiary enrollment in benchmark and equivalent plans, but “traditional” Medicaid must be available to categorically needy beneficiaries, hospice patients, medically frail or special needs individuals, beneficiaries qualifying for long-term care services, or women whose coverage is based on their eligibility under the breast and cervical cancer programs. Id.; 42 C.F.R. § 440.335; see also Sarah Rosenbaum and Anne Markus, The Deficit Reduction Act of 2005: An Overview of Key Medicaid Provisions and Their Implications for Early Childhood Development Services, The Commonwealth Fund (Oct. 2006), at 36.

A state is permitted to modify coverage or services to specific beneficiary populations by using a § 1915(b) waiver. 42 U.S.C. § 1396n(b). A 1915(b) waiver allows states to implement a primary care case-management system or a specialty physician services arrangement that restricts the provider to whom a beneficiary may visit to obtain medical services. Id. The waiver also allows states to vary which benefits are

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**Figure 3: Mandatory Medically Needy Services**

1. Prenatal care and delivery services for pregnant women;
2. Ambulatory Services as defined under the State Plan for children under the age of 18 and institutionalized individuals; and
3. Home health and services for individuals otherwise entitled to skilled nursing facility services.

A state can elect to include institutional services for mental disease services (excluding individuals from ages 22-64) or intermediate care facility services for the mentally retarded. If the state provides coverage, the state must also cover:

1. All mandatory services for the mandatory categorically needy listed in Figure 1, or
2. Seven additional benefits available to the mandatory categorically needy or the optional services listed in Figure 2.

available to beneficiaries based on geographic region and other factors. *Id.* States that choose to operate their Medicaid program under a waiver are required to ensure that beneficiaries continue to have accesses to quality medical services when medically necessary. *Id.*

Demonstration projects are time-limited waivers of Medicaid eligibility and coverage restrictions that allow a state to expand or reform coverage of certain populations, provided that the waiver is “likely to assist in promoting the objectives of the Medicaid statute.” 42 U.S.C. § 1310; Smith, at 28. States are not permitted to require individual Medicaid beneficiaries to participate in a demonstration project. 42 U.S.C. § 1310(b)(2)(B).

**B. The Administration of Benefits**

**1. Generally**

In addition to the flexibility that states are granted to determine eligibility and benefit coverage for Medicaid beneficiaries, states also have the ability to choose from two different delivery systems: fee-for-service (traditional Medicaid) or managed care. 42 U.S.C. § 1396u-2. Under the managed care option, there are two common program models: risk based managed care organizations (“MCOs”) and primary care case management (“PCCM”). *Medicaid and Managed Care: Key Data, Trends, and Issues*, Kaiser Commission on Medicaid and the Uninsured (Feb. 1, 2012) available at [https://www.kff.org/medicaid/issue-brief/medicaid-and-managed-care-key-data-trends/](https://www.kff.org/medicaid/issue-brief/medicaid-and-managed-care-key-data-trends/) (accessed Jan. 12, 2019). The key difference between the two models is the way in which the state compensates the managed care contractor for administering services to beneficiaries. MCOs are paid on a capitation basis, which means that the MCO is paid a monthly fee per enrollee. *Id.* As a result, an MCO assumes the financial risk for offering comprehensive care to enrollees when care for a beneficiary exceeds the capitation amount. *Id.* On the other hand, for PCCMs the state contracts with the beneficiary’s primary care physician who provides, manages and monitors the beneficiary’s primary care and is frequently responsible for authorizing specialty care. The primary care physician is paid a small per patient monthly fee for care management and on a fee-for-service basis for all other services. *Id.*

2. Cost Sharing

Even under traditional Medicaid, states are permitted to impose cost sharing measures on Medicaid benefits; this includes enrollment fees, premiums, deductibles, coinsurance, and co-payments offset the cost of providing care. 42 U.S.C. § 13960. However, there are limits on the services, amounts, and beneficiary groups for cost sharing initiatives. Elicia Herz, Medicaid: A Primer, Congressional Research Service (July 15, 2010). If a state imposes copayment obligations on beneficiaries, state discretion regarding the amount of the copay is limited. The SSA stipulates that the amount of the copayment must be “nominal.” 42 U.S.C. § 13960; 42 C.F.R. § 447.53(a). In 2009, the maximum copayment allowed for services ranged from $1.15-$5.70. 42 C.F.R. § 457.55. After fiscal year 2009, “any copayments may not exceed these amounts as updated each October 1 by the percentage increase in the medical care component of the CPI-U for the period of September to September ending in the preceding calendar year and then rounded to the next higher 5-cent increment.” Id. at § 457.55(a)(1)(ii).

Furthermore, states are prohibited from imposing co-payment obligations on services (1) provided to children under the age of 18, (2) related to pregnancy or any other medical condition that may complicate pregnancy, (3) emergency services, (4) furnished to individuals in inpatient hospitals, facilities, or institutions, (5) rendered to hospice patients, and (6) provided for family planning. 42 U.S.C. § 13960(b)(2).

Similarly, enrollment fees and premiums cannot be imposed on care for pregnant women, infants under the age of 1 year, a disabled child, qualified disabled and working individuals, and Native Americans. 42 C.F.R. § 447.56(a). The regulations also set forth both minimum and maximum enrollment and premium limitations based on the gross family income of the beneficiary. Id.

C. The Medicaid-Provider Relationship

Physicians, providers, and their respective entities are required to enroll in Medicaid to be reimbursed for services provided under a state’s Medicaid program. Provider enrollment is typically processed through the Medicaid Management Information System (“MMIS”) which is an integrated computer system that is designed to facilitate the management of claims payment, reporting, system controls, administrative costs, and information retrieval. Legislative Brief: Medicaid Management Information Systems, The Georgia DCH, March 2009. States can manage MMIS internally or can contract with a fiscal agent to manage the System. Id.

In addition to enrolling to be reimbursed, the ACA now requires physicians or other eligible practitioners to enroll in the Medicaid Program to order, prescribe and refer items or services for Medicaid beneficiaries, even when they do not submit claims to Medicaid. 42 C.F.R. § 455.410(b). The new enrollment requirement for these providers does not mean that they must also see Medicaid patients or be listed as a Medicaid provider for patient assignments or referrals. Instead, the new requirement is part of the ACA’s new program integrity requirements designed to ensure all orders, prescriptions, or referrals for items or services for Medicaid beneficiaries originate from
appropriately licensed practitioners who have not been excluded from Medicare or Medicaid.

For a provider to be eligible to bill Medicaid for their services, providers are required to enter into a provider agreement with the state, whereby among other things the provider agrees to accept Medicaid reimbursement for the services and not to request additional compensation from Medicaid beneficiaries. Smith, at 22. A state is required to set reimbursement rates to providers at levels “sufficient to enlist enough providers so that care and services available under the [Medicaid program] at least to the extent that such care and services are available to the general population in the geographic area.” 42 U.S.C. § 1396(a)(30)(A).

The rates paid to providers must also be consistent with “efficiency, economy, and quality of care.” Id. This statutory requirement has been interpreted by CMS to place an upper payment limit on provider payment rates. Smith, at 23. If a state elects to make payments to providers that exceed the upper limits specified by CMS, the state will not receive federal matching funds for those payments. 42 C.F.R. § 447.257; Smith, at 23. Generally, for inpatient providers (hospitals, nursing facilities, and intermediate care facilities for the mentally handicapped) and outpatient providers (hospitals and clinics), the payment limit takes into account the “aggregate Medicaid payments to a group of facilities” and cannot exceed “a reasonable estimate of the amount that would be paid for services furnished by the group of facilities under Medicare payment principles...” 42 C.F.R. §§ 447.272, 447.321; Smith, at 23. For other inpatient and outpatient providers, states are permitted to pay the “customary charges of the provider but must not pay more than the prevailing charges in the locality for comparable service under comparable circumstances.” 42 C.F.R. § 447.325.

III. Georgia Medicaid

A. Eligibility

Georgia extends Medicaid eligibility to optional categorically needy beneficiaries who (1) live in nursing homes; (2) are aged, blind or disabled and need regular nursing care and personal services but can stay at home with special community care services; (3) are terminally ill; and (4) medically needy pregnant women and children and aged, blind and disabled individuals. Eligibility Criteria Chart, Georgia Department of Community Health, https://dch.georgia.gov/services/eligibility-criteria-chart (accessed Jan. 12, 2019). Georgia also expands eligibility to (1) pregnant women and their infants up to 200% of FPL, (2) children under the age of 1 up to 185% of FPL, and (3) children whose family income is 133% of FPL. Id. Furthermore, Georgia operates the Katie Beckett Medicaid Program (“Katie Beckett”). This program allows children who qualify as disabled under 42 U.S.C. § 1382c to also attain eligibility for Medicaid benefits if a severely disabled child lives at home instead of in an institution. Id. Additionally, the child must be financially ineligible for social security. Fact Sheet: TEFRA/Katie Beckett Program, Georgia Department of Community Health (Sept. 2017), available at https://dch.georgia.gov/sites/dch.georgia.gov/files/related_files/document/17KatieBecKett.pdf (accessed Jan. 12, 2019)
B. Covered Services

Georgia has expanded eligibility to medically needy beneficiaries, so benefits in Georgia include the complete list of mandatory medically needy benefits listed above in Figure 3. Georgia Medicaid's major services include prescription drug coverage, doctor visits, inpatient and outpatient hospital care, lab tests, x-rays, home health care, hospice care, medical equipment and supplies, non-emergency medical transportation services, and dental care (up to age 21). See https://medicaid.georgia.gov/additional-medicaid-faqs (accessed Jan 12, 2019).

C. The Administration of Benefits

The Georgia Department of Community Health (“DCH”) currently contracts with four private care management organizations (“CMOs”) through a program called Georgia Families to provide managed care plans to Medicaid beneficiaries. See https://medicaid.georgia.gov/georgia-families (accessed Jan. 12, 2019). The four CMOs in Georgia are Amerigroup, CareSource, Peach State Health Plan, and WellCare of Georgia. Id. For eligible and non-statutorily excluded groups, enrollment in a CMO is mandatory. Id. Beneficiaries are permitted to select the CMO from which they wish to receive services, but if they fail to do so Georgia Families will select a plan for them. Id. Under a new program called Georgia Families 360°, Georgia offers a new managed care program for the approximately 27,000 children, youth, and young adults in foster care, children and youth receiving adoption assistance, and select youth involved in the juvenile justice system. See https://medicaid.georgia.gov/georgia-families-360° (accessed Jan. 12, 2019). The program was launched 2014 with Amerigroup providing health care coverage for these populations.

D. The Medicaid-Provider Relationship

The conditions for participation in Georgia Medicaid are available in Part I of the Policies and Procedures for Medicaid/Peachcare for Kids Manual. All providers are required to be licensed without restriction and certified under applicable state and federal laws to perform the applicable category of service. Id. Generally, the conditions of participation require providers to bill DCH appropriately for services, not pay for referrals, or solicit patients through offering free services, appropriately maintain patient records, and comply with DCH requests for information. Providers are also prohibited from contracting with any person or entity previously terminated or suspended from participation in the Medicaid program. Id.

DCH’s Division of Medicaid is responsible for Medicaid provider enrollment and DXC Technology is the fiscal agent that manages the Georgia MMIS (“GAMMIS”). All providers must enroll online. DCH Fact Sheet, available at http://dch.georgia.gov/sites/dch.georgia.gov/files/14-online-enroll-only.pdf. GAMMIS is the system used by providers to complete the initial enrollment process or update practice information. See https://www.mmis.georgia.gov/portal/ (accessed Jan. 12, 2019).
Providers participating in the Medicaid program including physicians, osteopaths, nurse practitioners and physician assistants are required to enroll. *Id.* Additional documentation is required for all applications: provider’s license, DEA Certificate, Board Certificate for Nurse Practitioners and a job description from the Georgia Composite Medical Board for Physician Assistants. If the provider reassigns his or her benefits to an entity that bills for services a power of attorney form is also required.

Georgia Medicaid enrolls providers and assigns Medicaid provider numbers to each location where a provider practices, including hospital locations. The provider will receive a Medicaid number for each location in which he or she is enrolled. Providers submit online applications via the GAMMIS website.

Under traditional Medicaid, Georgia pays providers on a fee-for-service basis. DCH reimburses providers “the lower of the physician’s lowest price regularly and routinely offered to any segment of the general public for the same service or item on the same date of service, the lowest price charged to other third party payers, or the statewide maximum allowable reimbursement allowed for the procedure code reflecting the service rendered. Part II Policies and Procedures for Physician Services, Georgia DCH, January 1, 2013, X1. Services of a physician assistant are limited to no more than 90% of the maximum allowable amount paid to a physician. *Id.* at X-2. DCH also publishes a schedule of maximum allowable payments for all provider types through the MMIS website.

As a condition of payment, DCH requires most providers to submit claims for payment using the CMS-1500 form. Georgia Medicaid/PeachCare for Kids Provider Billing Manual CMS 1500, at 19-20. Claims must be coded to reflect the appropriate services rendered and be submitted within six months from the date that the service was rendered. *Id.*

1. **Revalidation**

Medicaid enrolled providers must also revalidate their Medicaid enrollment with the State of Georgia. Providers must revalidate with Georgia Medicaid even if they have already revalidated with Medicare. Providers who did not complete revalidation within 60 days will have their enrollment deactivated or terminated from the Georgia Medicaid/PeachCare program. Unlike Medicare revalidation, DCH requires all providers to revalidate online only using the GAMMIS.

CMS has tried to align the Medicare and Medicaid revalidation requirements by requiring similar data input and revalidation timelines. Both Medicare and Medicaid revalidation focus on verification of a provider’s current enrollment status by requiring providers to verify their name, date of birth, Social Security Number, NPI, Tax ID number and license numbers. In addition, Medicaid revalidation similarly follows the a five-year revalidation cycle as Medicare. *Id.*
IV. **Conclusion**

Medicare and Medicaid fill important gaps in access to medical coverage for many individuals, but the administration of these programs is notably complex. Attorneys representing client beneficiaries and medical providers must have a strong grasp on the ins and outs of these programs to ensure effective representation.
TOPICS

• False Claims Act
• Anti-Kickback Statute
• Emergency Medical Treatment and Active Labor Act
Who Is The Federal Government?

- Centers for Medicare and Medicaid Services (“CMS”)
- Office of Inspector General HHS
- Federal Bureau of Investigation
- Department of Justice

Who Helps The Government?

- Patients
- Program Beneficiaries
- Employees
- Qui Tam Relators
  - (Whistleblowers)
False Claims Act

- Lincoln sponsored FCA in 1863
- Originally intended to reach defense contractor fraud against federal government
- Evolved to reach all fraudulent claims for reimbursement intended to get the government to pay money for property or services
- Deputizes private citizens as attorney generals, bounty hunters, or “relators” entitled to a % of government’s recovery

Civil False Claims Act

- Government's most important tool to combat health care fraud and abuse
- Prohibits knowingly submitting or causing to be submitted a false claim for payment to the government or using a false record to get claim approved
- About 50% of FCA cases involve health care fraud
- Up to 10 year statute of limitations
  
  31 U.S.C. § 3729 et seq.
FUNDAMENTALS OF HEALTH CARE LAW
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Criminal False Claims Act

“Knowingly and willfully makes or causes to be made any false statement or representation of a material fact” to obtain benefit from program

42 U.S.C. § 1320a-7b

FCA Liability

Cost of Non-Compliance
- Internal investigation, defense & remedy
- Attorney’s Fees
- Civil & Administrative penalties

Civil & Administrative Penalties
- Per Claim - $11,181 to $22,363
- Treble Damages of the government’s loss
- Possible exclusion from participation in federal health care programs
- Potential Individual Exposure
Yates Memo

• Former Deputy Attorney General Yates—2015 Memorandum to U.S. Attorneys regarding individual accountability for corporate wrongdoing
  – Instructs U.S. Attorneys to focus efforts on holding individual wrongdoers accountable for illegal activity
  – To be eligible for any cooperation credit, corporations must provide to DOJ all facts regarding individuals involved in corporate misconduct

Yates Memo (continued)

– Both criminal and civil corporate investigations should focus on individuals from the outset
– Absent extraordinary circumstances, no corporate resolution will provide protection from criminal or civil liability for individuals

• Recently, Deputy AG Rosenstein reaffirmed that underlying policy of holding individuals accountable for corporate wrongdoing will be kept in place
• Recent example of substantial fines assessed against individual former health care executives under the individual accountability policy in corporate fraud cases
FUNDAMENTALS OF HEALTH CARE LAW
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Why Does The Government Use The Civil False Claims Act?

• Lower standard of proof
• Lesser intent requirement - “knowingly” means with “actual knowledge” of facts or “deliberate ignorance” of the true facts or in “reckless disregard” of the facts
• Potent Fraud Fighting Tool—treble damages, penalties, exclusion

Use Of The False Claims Act

• National initiatives (off-label promotion of prescription drugs)
• Knowing Retention of Overpayments
• Services not rendered
• Upcoding
• Cost reporting
• Quality of care
• Stark/Anti-Kickback
Whistleblowers or Relators

- Generate vast majority of FCA cases
- Retaliation cause of action
- Right to attorney’s fees, costs & expenses
- Relator’s role
  - Limited party if Government intervenes
  - Principal party if Government declines
- Government always real party in interest
- Relator’s share
  - If Government Intervenes = 15-25%
  - If Government does not intervene = 25-30%

Recent Developments in FCA Litigation

- 2018 DOJ Memorandum re: Potential Dismissal of Certain FCA Cases
60-Day Medicare and Medicaid Overpayment Statute
42 U.S.C. § 1320a-7k(d)(1)-(2)

- Provision of PPACA (2010)—Imposes False Claims Act liability where provider fails to report and return Medicare/Medicaid overpayment within 60 days of identification of overpayment
- “Overpayment” defined as any funds that a person receives or retains under Medicare or Medicaid laws to which person, after applicable reconciliation, is not entitled

CMS's 60-Day Final Rule

- February 12, 2016 CMS Final Rule (81 Fed. Reg. 7653) requires reporting and returning of Medicare overpayments within 60 days after overpayment has been “identified”
- Places substantial duties on providers
CMS's 60-Day Final Rule

• An overpayment is “identified” when a “person has, or should have through the exercise of reasonable diligence, determined that the person has received an overpayment and quantified the amount of the overpayment.”

CMS's 60-Day Final Rule

• Good faith “reasonably diligent” investigation must be undertaken in response to “credible information” suggesting an overpayment may exist
• What constitutes “credible information?”
CMS's 60-Day Final Rule

• Application of 60-day report and refund duty?
• Often complex billing questions necessitate thorough and time-consuming “investigation”
• CMS guidance in final rule—investigation should take at most 6 months (except under extraordinary circumstances)

CMS's 60-Day Final Rule

• Lookback period?
• Proposed rule suggested a possible 10-year lookback period (i.e., investigate the existence of the overpayment 10 years back)
• Final Rule settled on a 6-year lookback period
CMS's 60-Day Final Rule

- Addresses duty to report and refund Medicare overpayments
- What about Medicaid overpayments?
  - See 42 U.S.C. § 1320a-7k(d)
- What about overpayments received from
  - Medicare Advantage plans?
  - Medicaid Care Management Organizations?

Recent Developments in Application of 60-Day Rule

- Recent settlement announced by OIG – Cancer Center provider agreed to pay civil monetary penalty for allegedly failing to timely return overpayments after provider realized refund was due
- Recent Medicare Administrative Contractor correspondence concerning overpayments also includes explicit language reminding providers of refund duty under 60-Day Rule
  - Impact on 60-Day Rule addressing provider Medicare overpayments?
Anti-Kickback Statute - Generally

• In some industries, it is acceptable to reward those who refer business to you. Not so in health care.

• Intended to prevent
  – Corruption of medical judgment
  – Overutilization of items or services and corresponding increase in program costs
  – Unfair competition

Anti-Kickback Statute

• Prohibited Conduct:
  – Knowing and willful
  – Solicitation or receipt or offer or payment of
  – Remuneration
  – In return for referring a federal health care program patient, or
  – To induce the purchasing, leasing, or arranging for or recommending purchasing or leasing items or services paid by the program

42 U.S.C. § 1320a-7b
Anti-Kickback Statute - Scope

• Very broad – applies to all people and entities, not just physicians
• Any form of “remuneration” to induce or reward referrals
  – Money (traditional “kickbacks”)
  – Free or discounted items or services (e.g., perks, gifts, space, equipment)
  – Anything of value!

Anti-Kickback Statute

Penalties
• Criminal fines & imprisonment
• Civil money penalty of $50,000 plus 3X the amount of the remuneration
• Exclusion
• False Claims Act liability
“INTENT TO INDUCE”

United States v. Greber (3rd Circuit 1985)
• If one purpose of the fee was to induce the ordering of services from defendant’s company, the statute was violated

Anti-Kickback Statute
• Statutory Exceptions
  – Discounts
  – Bona fide employment relationships
  – Certain copayment waivers
  – Certain managed care arrangements
• Safe Harbors (42 C.F.R. § 1001.952)
Anti-Kickback Statute

- Joint Ventures
- Vendor Relationships
- Service Agreements
- Leases (Space and Equipment)
- Discounts
- Fair Market Value
- Physician Recruitment
- Personal Service Contracts

Anti-Kickback Statute - Analysis

- Is the AKS implicated?
- If yes – does arrangement fit within exception or safe harbor?
- If no – does arrangement pose more than a minimal risk of fraud and abuse?
  - Totality of facts and circumstances
  - Ultimate question: whether “one purpose” is improper
Risk Reduction Analysis

- Fraud Alerts
- OIG Guidance – Advisory Opinions, Compliance Guidance
- Industry Practice and Guidance

Anti-Kickback Statute

Things to remember:
- Anti-kickback law applies to everyone
- Anti-kickback law contains an intent element
- The anti-kickback law is criminal
- Under anti-kickback statute, behavior or relationships falling outside of a safe harbor may be permissible

- To establish violation of anti-kickback statute, government does not have to prove that person had “actual knowledge” of statute or specific intent to violate statute.
- A violation of anti-kickback statute constitutes false or fraudulent claim for purposes of False Claims Act.

Role of Legal Counsel

- Compliance Programs
- Prevention (Education and Training)
- Government Sources:
  - www.oig.hhs.gov
  - Compliance Program Guidance
  - Advisory Opinions
  - OIG Work Plans
Emergency Medical Treatment And Active Labor Act (1986)

• Originally enacted to prohibit hospitals from “dumping” patients, by transferring or refusing to treat if unable to pay
• EDs are now America’s health care safety net

EMTALA Basics

When individual comes to emergency department and makes request for treatment:
• Must provide appropriate Medical Screening Examination (MSE) without delay; AND

If Emergency Medical Condition (EMC) exists:
• Provide stabilizing treatment before discharge; OR
• Transfer to another hospital, if appropriate.

Source: 42 U.S.C. § 1395dd
42 C.F.R. § 489.24
Obligation Of “Receiving” Hospitals

- **Must accept** patient who needs special capabilities or facilities if hospital has capacity
  
  42 C.F.R. § 489.24(f)

**EMTALA HONOR CODE**

**Thou shalt not dump patients.**

42 C.F.R. § 489.20(l)
On Call Physician Responsibility

If you are on call, you must come in if called by ER doctor

State Operations Manual at A404

EMTALA = STRICT LIABILITY

Motive for the violation does not matter!
Enforcement/Penalties

- Complaint Driven
- Possible Exclusion from Medicare
- Up to $50,000 fine for smaller hospitals and up to $100,000 for larger hospitals
- Private right of action for “personal harm”
I. • Topics

A. • False Claims Act
B. • Anti-Kickback Statute
C. • Emergency Medical Treatment and Active Labor Act ("EMTALA")

II. • Who is the Federal Government?

A. • Centers for Medicare and Medicaid Services ("CMS")
B. • Office of Inspector General Health & Human Services
C. • Federal Bureau of Investigation
D. • Department of Justice
E. • But that's not all…

1. • The DOJ includes the local U. S. Attorney. Each of the 93 U. S. Attorney's Offices has a designated criminal Health Care Fraud Coordinator and a Civil Health Care Fraud Coordinator. Also, IRS, Postal Service, and Defense Criminal Investigative Service. States also get involved through Medicaid Fraud Control Units.

F. • Why so many enforcement agencies? $$$ During FY 2018, the federal government won or negotiated $2.5 billion in civil health care fraud judgments and settlements. Between 2015 and 2017, for every $1.00 the federal government spent on health care fraud enforcement, it returned $4.20.

III. • Who Helps the Government?

A. • Patients
   1. • 1-800-HHS-TIPS
   2. • EOBs
B. • Employees
C. • Qui tam relators (whistleblowers) - usually patients or employees.
D. • Providers, through self-disclosure.
E. Most of the big investigations originate from one of these areas. However, the
government does engage in some data mining and investigation.

IV. False Claims Act

A. Introduction

1. Lincoln sponsored the False Claims Act ("FCA") in 1863.

2. The statute was originally intended to reach defense contractor fraud against
   federal government.

3. The FCA evolved to reach all fraudulent claims for reimbursement intended to
   get the government to pay out money for property or services.

4. The statute deputizes private citizens as attorney generals, bounty hunters, or
   "relators" entitled to a percentage of the government's recovery.

5. Since the 1986 amendments to the whistleblower provisions, more than half of
   FCA suits have been brought against the health care industry.

   a) Over $13 billion has been recovered from the health care industry in the
      first 20 years of the FCA (1987-2007).

    (1) $2.5 billion recovered from the health care industry in FY 2018.

   b) 74% of qui tam recoveries under the FCA have been from the health care
      industry.

   c) In FY 2018, $301 million was paid to qui tam relators who filed
      whistleblower actions.


1. The Civil False Claims Act is the most important tool of government to combat
   health care fraud and abuse.

2. The Civil FCA prohibits knowingly submitting or causing to be submitted a false
   claim for payment to the government or using a false record to get a claim approved.

   a) The FCA is violated through submission of a false claim, submission of a
      false record to get a claim paid, or conspiring to get a false claim paid.

    (1) Reverse false claim - maintaining a false record to decrease
        obligation to pay money to the government.

   b) Knowingly:
(1) Actual knowledge;
(2) "Deliberate ignorance;" or
(3) "Reckless disregard."

c) "False" claim

(1) If reasonable minds differ - is it false?

(a) See United States v. Whiteside, 285 F.3d 1345 (11th Cir. 2002) (reversing criminal convictions where defendants' interpretation not unreasonable).

3. Substantial number of FCA cases involve health care fraud.

a) 4 cases in 1987; 310 cases in 1999; 110 new cases in 2006.

b) In FY 2017, U. S. Attorney's Offices opened 948 new civil health care fraud cases.

c) Recoveries over $1 billion every year since 2003.

4. Up to 10 year statute of limitations.

a) When does it run?

b) 6 years after violation or 3 years after material facts are known, but not more than 10 years.

C. Criminal False Claims Act - 42 U.S.C. § 1320a-7b

1. "Knowingly and willfully makes or causes to be made any false statement or representation of a material fact" to obtain benefit from the program.

2. "Willfulness" is the heightened standard of proof.

D. FCA Liability

1. Cost of non-compliance

a) Internal investigation, defense and remedy;

b) Attorney's fees;

c) Civil and administrative penalties;

(1) $11,181 to $22,363 per claim as of January 29, 2018;
(2) Treble damages of the government's loss;

(3) Possible exclusion from participation in federal health care programs;

(4) Potential individual exposure.

d) Effect of voluntary disclosure

(1) Damages under the FCA are limited to double damages suffered by the government if the provider voluntarily discloses the false claims to the government within thirty (30) days of learning of the violation and prior to any government investigation involving the claims.

E. Why does the Government use the Civil False Claims Act?

1. Lower standard of proof
   a) Preponderance of the evidence standard.

2. Lesser intent required - "knowingly" means with "actual knowledge" of the facts or "deliberate ignorance" of the true facts or in "reckless disregard" of the facts.
   a) Not "willfully;"
   b) See U.S. v. Laughlin, 26 F.3d 1523 (10th Cir. 1994) (criminal act requires knowledge that claims were false).


F. Uses of the False Claims Act

1. National initiatives (PATH, DRG 79; off-label promotion and marketing of prescription drugs);

2. Services not rendered;

3. Upcoding;

4. Cost reporting;

5. Quality of care;

6. Stark/Anti-Kickback:
   a) Physician relationships;
   b) Vendor relationships;
7. Examples:
   a) United States v. Rogan, 517 F.3d 449 (7th Cir. 2008).
      (1) $64 million judgment against CEO where a variety of contracts were used to disguise kickbacks;
      (2) Medical directors, physician recruitment, teaching, EKG reading - compensation "grossly" above fair market value.
   b) Example of acute care hospital settlements:
      (1) Hospital agreed to pay $5.7 million to settle FCA and Stark allegations. FCA and Stark violations alleged where medical director agreement was above fair market value and physicians were permitted to use hospital employees free of charge.
      (2) Large operator of acute care hospitals agreed to pay $98 million to settle allegations that it billed Medicare, Medicaid, and TRICARE for inpatient services that should have been provided in less costly outpatient or observation setting.
      (3) Hospital paid $85 million to resolve alleged violations of Stark.

G. Whistleblowers or Relators
   1. The best way to catch a rogue is with a rogue - Sen. Grassley.
      a) Qui tam relators are often insiders/former employees.
   2. Relator also has the benefit of a retaliation cause of action.
   3. Relator is entitled to attorney's fees, costs and expenses.
   4. Relator's role:
      a) Limited party if government intervenes;
      b) Principal party if government declines;
      c) Government is always real party in interest.
   5. Relator's share:
      a) If government intervenes = 15-25%;
      b) If government does not intervene = 25-30%.

H. Fraud Enforcement Recovery Act of 2009
1. 2009 Amendments to False Claims Act.
2. Improper retention of overpayments is the basis of FCA action.
3. Expanded liability for claims not submitted directly to government.
4. Expanded retaliation provisions.
5. Expanded statute of limitations.
7. Greater cooperation between government and whistleblowers.

I. The Patient Protection and Affordable Care Act of 2010 ("PPACA")

1. Imposes FCA liability where provider fails to report and return Medicare/Medicaid overpayment within 60 days of identification of overpayment.

2. “Overpayment” defined as any funds that a person receives or retains under Medicare or Medicaid laws to which person, after applicable reconciliation, is not entitled.

V. Anti-Kickback Statute - 42 U.S.C. § 1320a-7b

A. Introduction

1. The Anti-Kickback Statute ("AKS") is the second fundamental statute the government uses to prosecute health care fraud.

2. Prohibited conduct:
   a) Knowing and willful
   b) Solicitation or receipt or offer or payment of
   c) Remuneration
   d) In return for referring a federal program patient, or
   e) To induce the purchasing, leasing, or arranging for or recommending purchasing or leasing items or services paid by the program.

3. AKS also applies to inducements to beneficiaries.

4. Prohibits payment, solicitation, receipt, or offer;
   a) Limited to federal program patients;

5. Remuneration is broadly defined - i.e., any benefit.
a)• Direct or indirect;
b)• Overtly or covertly;
c)• In cash or in kind.

B.• Penalties

1. • Criminal fines and imprisonment;
   a)• Up to $25,000 fine and five years in prison;

2. • Civil monetary penalty of $50,000 plus three times the amount of the remuneration;

3. • Exclusion from participation in federal health care programs;

4. • Liability under the False Claims Act:
   a)• The 11th Circuit has held that violating the Anti-Kickback Statute is a false claim under the FCA. See U.S. ex rel. McNutt v. Haleyville Med. Supplies, Inc., 423 F.3d 1256 (11th Cir. 2005).
   b)• PPACA includes a provision that specifically establishes that every claim for items or services resulting from a violation of the AKS automatically constitutes a "false or fraudulent claim" under the FCA;

5. • Damage to reputation.

C. • "Intent to Induce"

1. • "One Purpose" Test
   a)• United States v. Greber, 760 F.2d 68 (3d Cir. 1985) - If one purpose of the fee was to induce the ordering of services from defendant's company, the statute was violated.

   (1)• Statute is violated even if another purpose is to compensate for professional services.

2. • In Chicago case (Rogan), compensation was "grossly" above fair market value for medical directors, teaching, EKG reading, etc.

3. • "[Defendants] cannot be convicted merely because they hoped or expected or believed that referrals may ensue from remuneration that was designed wholly for other purposes. Likewise, mere creation of an attractive place to which patients can be referred does not violate the law."

   a)• United States v. Anderson, 261 F.3d 993 (10th Cir. 2001) (Jury Instruction No. 32).
4. PPACA clarifies that, in order to establish a violation of the AKS, a person need not have actual knowledge of the AKS or specific intent to commit a violation of the AKS.

   a) United States v. St. Junius, 739 F.3d 193 (5th Cir. 2013)-Section 1320a-7b(h) clarifies that the Government is not required to prove actual knowledge of the Anti-Kickback Statute or specific intent to violate it. Instead, the Government must prove that the defendant willfully committed an act that violated the Anti-Kickback Statute.

D. Statutory Exceptions - 42 U.S.C. § 1320a-7b(b)(3)

1. Discounts;
2. Bona fide employment relationships;
3. Amounts paid by providers to a group purchasing organization;
4. Certain waivers of coinsurance;
5. Activities that are protected by the safe harbor regulations;
6. Certain risk sharing arrangements;
7. Certain waivers or reductions by pharmacies of cost sharing obligations;
8. Certain managed care arrangements;
9. Hardware, software, or information technology and training services used to receive and transmit electronic prescription information (see 42 U.S.C. § 1395w-104(e)).

E. Safe Harbors - 42 C.F.R. § 1001.952

1. Investment interests;
   a) Large publicly traded entities;
   b) Small entities;
2. Space rental;
3. Equipment rental;
4. Personal services and management contracts;
5. Sale of practice;
6. Referral services;
7. Warranties;
8. Discounts;
9. Employees;
10. Group purchasing organizations;
11. Waiver of co-insurance and deductibles;
12. Increased coverage, reduced cost-sharing amounts, or reduced premium amounts offered by health plans;
13. Price reductions offered to health plans;
14. Practitioner recruitment;
15. Obstetrical malpractice insurance subsidies;
16. Investments in group practices;
17. Cooperative hospital service organizations;
18. Ambulatory surgical centers;
19. Referral arrangements for specialty services;
20. Price reductions offered to eligible managed care organizations;
21. Price reductions offered by contractors with substantial financial risk to managed care organizations;
22. Ambulance replenishing;
23. Health centers;
24. Electronic prescribing items and services;
25. Electronic health records items and services.

F. Applies to just about every aspect of the relationships between providers, their referral sources, vendors and patients. Also, cannot induce them not to order - i.e., inducement to physicians to order fewer services or tests (also CMPs).

1. Orthopedic implant manufacturers case - Four major producers of artificial hips and knees agreed to pay a total of $310 million in penalties to settle federal accusations that they used fake consulting agreements and other tactics to get surgeons to use their products.
2. **Hospital/Physician recruitment** - $21 million settlement of allegations involving relocation funds that went directly to physicians.

3. **Acute care hospital/Physician relationships** - allegations cost Hospital $5.7 million to resolve.

4. **United States v. Rogan (7th Cir.)** - $64 million judgment against CEO-medical director agreement, etc. used to disguise kickbacks.

G. **Risk Reduction Analysis**

1. Arrangements must be close to the safe harbors;
   a) Failure to satisfy a safe harbor does not necessarily result in prosecution by OIG.
   b) According to the OIG, the "degree of risk depends on an evaluation of many factors."

2. Fraud alerts;

3. **OIG Guidance**;
   a) Advisory opinions;
   b) Compliance guidance;

4. **Industry practice and guidance**;
   a) PhRMA, AMA.

H. **Things to Remember**

1. The Anti-Kickback Statute applies to everyone.

2. The Anti-Kickback Statute contains an intent element.

3. The Anti-Kickback Statute is criminal.

4. Under the Anti-Kickback Statute, behavior falling outside of a safe harbor may be permissible.

I. **Role of Legal Counsel**

1. Compliance programs
   a) Policies to help prevent, detect and report fraud or false claims;
   b) OIG/CMS have provided guidance;
c) Every hospital and most physician groups should have one.

2. Prevention
   a) Education and training;
   b) The role of counsel prior to being faced with potential health care fraud issue - prevention.

3. Government sources:
   a) www.oig.hhs.gov;
   b) Compliance Program Guidance;
   c) Advisory Opinions;
   d) OIG Work Plans.

VI. Emergency Medical Treatment and Active Labor Act (1986)

A. Introduction
   1. Originally enacted to prohibit hospitals from "dumping" patients, by transferring or refusing to treat them if they are unable to pay.

   2. Emergency departments are now America’s health care safety net:
      a) Over 28 million Americans lack health insurance;
      b) ED is primary component of health care delivery - substantial number of ED visits involve clinically non-urgent complaints;
      c) Point - highly utilized EDs result in delays in treating truly emergent patients and higher costs.

   1. When a patient comes to the ED and a request for examination or treatment is made:
      a) The hospital must provide appropriate Medical Screening Exam ("MSE") without delay;
      b) If emergency condition exists, treat it;
      c) Stabilize;
      d) Transfer if appropriate; and
e) Discharge.

2. Definitions:

a) MSE is not defined - must be within the capabilities of the hospital, including ancillary services routinely available to the ED, by "qualified medical personnel."

b) "Emergency medical condition" - acute symptoms of sufficient severity (including severe pain) requiring immediate medical attention.

c) "Stabilized" - no material deterioration of condition is likely during, or as a result of, transfer, including discharge.

   (1) The provider only needs to stabilize to resolve the emergency condition, not resolve the illness.

3. EMTALA applies to all Medicare hospitals that have an ED when a patient presents on hospital property.

4. Key - cannot delay MSE or further treatment to inquire about method of payment.

   a) Do not delay or discourage treatment.

5. A hospital may transfer a patient prior to stabilization, if necessary, pursuant to certain restrictions.

C. Obligation of "Receiving" Hospitals - 42 C.F.R. § 489.24(f)

1. A "receiving" hospital must accept a patient who needs special capabilities or facilities if the hospital has capacity.

   a) "Reverse dumping" is prohibited - a hospital with special capabilities (burn unit, neonatal intensive care) may not refuse to accept a transfer.

2. The receiving hospital must have capacity.

3. Must be an "appropriate" transfer as defined by the regulations:

   a) Physician signed certification;

   b) Transfer of medical records, etc.

D. EMTALA Honor Code - 42 C.F.R. § 489.20(l), (m)

1. Thou shalt not dump.

2. Recipient of an inappropriate transfer must report within 72 hours.
3. Also, the statute has whistleblower protections prohibiting hospitals from taking retaliatory action against any physician, employee, etc. reporting an EMTALA violation.

E. On-Call Physician Responsibility - 42 C.F.R. § 489.24(j)

1. If a physician is on-call, that physician must come in if called by an ED physician;
   a) The on-call physician does not make the decision whether to come in - the ED physician does.

2. Hospitals must maintain an on-call list.

F. EMTALA = Strict Liability

1. Motive for the violation does not matter!

2. Despite the purpose of the statute, EMTALA does not just penalize errors that are motivated by financial screening.

G. Enforcement and Penalties

1. Enforcement is primarily complaint driven;
   a) Enforcement process usually involves notice of intent to exclude from Medicare; hospital files plan of correction (23 day process).

2. Penalties for a violation may include:
   a) Possible exclusion from Medicare;
   b) Up to $50,000 fine for smaller hospitals and up to $100,000 for larger hospitals;
   c) Private right of action for "personal harm;"
   d) Adverse publicity;
   e) Civil liability.
Rob Keenan focuses on healthcare regulatory and transactional matters. A partner in both our Healthcare and Data Security and Privacy practices, Rob represents health industry clients in a broad range of issues.

Rob advises health systems, hospitals, home health companies, pharmacy benefit management companies, pharmaceutical and medical device companies, physician organizations, and managed care companies on a wide range of federal and state regulatory matters, with a particular focus on health information privacy and security as well as fraud and abuse issues.

In addition, Rob represents health industry clients in transactional matters, including healthcare regulatory due diligence in connection with mergers and acquisitions, joint ventures between healthcare providers, managed care contracting and general contracting.

Rob is experienced in health information privacy issues for covered entities and business associates regulated by HIPAA and for medical device and pharmaceutical companies that encounter HIPAA-related issues. He also focuses on advising hospitals and health systems on regulatory and structuring issues related to physician practice acquisitions and employment.

A regular speaker and writer on health law issues, Rob has been recognized in recent editions of The Best Lawyers in America, the Chambers USA Client's Guide to America's Leading Lawyers for Business, and Guide to the World's Leading Healthcare Lawyers. He is an active member of the American Health Lawyers Association, the Health Law Section of the American Bar Association, and the State Bar of Georgia, and is also a member and past President of the Georgia Academy of Healthcare Attorneys.

Credentials

EDUCATION
J.D., University of Georgia, cum laude
B.S., University of Illinois, high honors

ADMISSIONS
Georgia
Charlotte Combre practices exclusively in the area of healthcare law, focusing primarily on the regulatory compliance of healthcare organizations. She has a depth of experience advising and representing healthcare clients on Medicare and Medicaid provider enrollment, billing and claims reimbursement, as well as state licensure and survey and accreditation matters. Representative clients include hospitals and hospital systems, physician groups, surgery centers, rehabilitation agencies, home health agencies, behavioral health facilities, IDTFs, long-term care facilities, ID/DD agencies, pharmacies, clinical laboratories and DMEPOS suppliers.

Charlotte has advised clients in relation to stock and asset acquisitions, mergers, joint ventures and internal reorganizations on transferring and obtaining permits, licenses and registrations, Medicaid and Medicare certifications, and billing privileges. Her practice includes structuring for compliance with state and federal laws and regulations, assisting with setting up entities, applying for NPIs, filing CMS 855 enrollment and state Medicaid applications. Charlotte also works with providers on revalidations of their Medicare and Medicaid enrollment and maintaining accurate PECOS records. In addition, she assists clients with initial state licensure applications and surveys, licensure updates and preparation of plans of correction. She also assists clients with initial CLIA applications, as well as maintaining and renewing CLIA certificates of waiver, provider performed microscopy, registration, compliance and accreditation certificates.

Charlotte regularly speaks on healthcare regulations, including having spoken at various seminars on the fundamentals of Medicare and Medicaid, and the retention and confidentiality of medical records.

Professional Associations and Community Involvement

Charlotte is active with American Health Lawyers Association, Center for Law Health and Society Advisory Board at Georgia State University College of Law, Georgia Academy of Healthcare Attorneys, State Bar of Georgia, Health Law Section (Past Chair); Georgia Associations of Black Women Attorneys Foundation (Vice President), and Bobby Dodd Institute, Inc. (Board Member).
biography

Jon Rue is a savvy advocate for healthcare providers. Over the course of his 35+ year career, Jon has handled a wide range of litigation, primarily arising out of healthcare regulation. He brings a confident, comprehensive approach to every case, ensuring that his clients are in the best possible position for a successful resolution.

Focused on healthcare regulatory litigation, Jon spends most of his time representing hospitals and other healthcare providers in proceedings in state and federal court, before regulatory agencies, and in arbitration and mediation. These matters include Medicare, Medicaid, and managed care payment disputes (including appeals of audit determinations), certificate of need litigation (including rule challenge proceedings), and other healthcare-related commercial disputes. Jon has also represented hospitals in a variety of regulatory matters, including Medicare and Medicaid decertification actions and EMTALA matters, and he is frequently called on for regulatory compliance advice.

Jon is fiercely committed to representing his clients’ rights and interests, and to keeping them informed throughout the litigation process. His deep knowledge of the healthcare landscape, coupled with his advocacy skills, allows Jon to provide comprehensive, highly effective representation for any regulatory issue his clients might face.

experience

- Served as lead counsel for hospital system in Provider Reimbursement Review Board appeal seeking substantial additional Medicare reimbursement for allowable Medicare bad debt.
- Served as lead counsel for hospital system in Provider Reimbursement Review Board appeal seeking substantial additional Medicare reimbursement for allowable Medicare Disproportionate Share of Hospital payments.
- Represented Hospital in litigation challenging the Florida Agency for Healthcare Administration’s published Medicaid outpatient payment rate.
- Served as lead counsel for Hospital in appeal of Zone Program Integrity Contractor audit and overpayment determination.
- Served as lead counsel for Hospital in connection with State Court litigation, American Arbitration Association Arbitration, mediation of Hospital/physician dispute, and sale of joint venture entity.
- Served as lead counsel for health system in connection with American Arbitration Association arbitration dispute with managed care payor alleging wrongful denials of payment for home health services.
• Served as lead counsel in American Arbitration Association arbitration dispute with Medicare Advantage managed care payor challenging reduced payment associated with Medicare sequestration reduction.

• Served as lead counsel in representation of not-for-profit hospital system in challenge to Georgia Department of Community Health’s assessment of hospital provider tax.

• Served as lead counsel in representation of hospital seeking Georgia CON approval for multi-specialty ambulatory surgery center and cancer center offering radiation therapy services.

• Obtained Certificate of Need for bone marrow transplant program over objection of existing provider. Proved the need for new program and substantial change of circumstances from previous application.

• Participated in 67-hospital coalition challenging a reduction in hospital payments by the Medicaid Program. After state agency denied standing, successfully appealed to the First District Court of Appeal, which remanded the case for adjudication.

• Successfully opposed Certificate of Need for hospital-based hospice program due to substantial adverse impact on existing provider of hospice services.

• Defended approval of Certificate of Need for new nursing home.

• Represented hospital system in response to EMTALA complaint and investigation. Representation included submission of acceptable Plan of Correction of cited deficiencies and response to CMS termination action and potential OIG action.

thought leadership

Presentations:

• Speaker, Compliance Hot Topics at the Association of International Certified Professional Accountants’ Health Care Industry Conference (November 2018)

• Speaker, Federal Healthcare Regulations (including the False Claims Act, the Anti-Kickback Statute, and the Emergency Medical Treatment and Active Labor Act) and Ethical Considerations at the Fundamentals of Health Care Law seminar co-sponsored by the Health Law Section, State Bar of Georgia, and the Georgia Academy of Healthcare Attorneys (March 2018)

• Speaker, Using Mediation and Arbitration in Health Care Cases at the 24th Annual ADR Institute and 2017 Neutrals’ Conference, co-sponsored by Georgia Office of Dispute Resolution and Dispute Resolution Section, State Bar of Georgia (December 2017)


• Speaker, Sales Tax Update, Georgia Alliance of Community Hospitals Annual Meeting (October 2008)


**accolades**

• Recognized as the 2019 “Lawyer of the Year” in Health Care (Atlanta) by *The Best Lawyers in America*

• Recognized as a leading Georgia healthcare lawyer in *Chambers: Leading American Business Lawyers*

• Recognized as a leading Health Care practitioner by *The Best Lawyers in America* (2006-present)

• Selected as a “Georgia Super Lawyer” by *Law & Politics Media* and *Atlanta Magazine* (2006 and 2008-present)

• Recognized as one of Georgia’s “Top Rated Lawyers” by *Martindale-Hubbell* and *ALM*

**professional affiliations**

• Serves on the Firm’s Professional Development Committee

• Georgia Academy of Healthcare Attorneys

• Healthcare Financial Management Association

• American Health Lawyers Association

• American Bar Association (Member, Health Law Section)

• State Bar of Georgia (Chair, Health Law Section, 2001-2002)

• The Florida Bar (Member, Health Law Section)

• Kentucky Bar Association (Member, Board of Directors, Young Lawyers Section, 1985-1986)

• Atlanta Bar Association (Member, Board of Directors, Atlanta Council of Younger Lawyers, 1988-1991)

**education**


• Western Kentucky University (B.A., *summa cum laude*, 1979) Omicron Delta Kappa; Phi Alpha Theta
10:00  STATE HEALTHCARE REGULATIONS
Kathlynn Butler Polvino, KBP Law, P.C., Atlanta
Rachel L. King, Georgia Department of Community Health, Atlanta
Roxana D. Tatman, Georgia Department of Community Health, Atlanta
Georgia’s Certificate of Need Program

Kathlynn Butler Polvino

Fundamentals of Healthcare Law
February 27, 2019

35 States*, D.C., Puerto Rico & the Virgin Islands have operated CON programs for 30-40 years.

CON in Georgia has been in place for nearly 40 years.

* NH repealed in 2016.
Certificate of Need is an “official determination” of the Georgia Department of Community Health that a new or expanded health care service or facility is needed and complies with the criteria contained in the CON law and regulations.
Goals of the Georgia CON Program

- To ensure that adequate health care services and facilities are:
  - available to the citizens of the State;
  - developed in an orderly and economical manner; and
  - provided in a manner that avoids unnecessary duplication
- To ensure that only health care services that are found to be in the public interest are offered
- To ensure that health care services meet the various needs of the different regions of the State

Scope of the CON Law

- **New Institutional Health Services**
  - A CON is required prior to offering or developing a “New Institutional Health Service” (which may be a capital expenditure)

- **Exemptions**
  - The statute delineates certain facilities, services, and expenditures that do not require a CON even though they may otherwise be “New Institutional Health Services.” However, confirmation of the exemption generally is required.
The Impact of CON Regulation

- CON is a potential barrier to market entry (new facilities/new services)
- CON considerations may impact or impede strategic initiatives for existing healthcare facilities and physicians (new or expanded services/new projects)
- CON considerations impact alignment strategies between various types of health care providers
- Unimplemented CONs may be at risk if facility transferred without permission from the Department

Source: American Health Planning Association 2016 Coverage Matrix
The Impact of CON Regulation

- CON considerations impact and may change the terms of transactions
  - What type of CON authorization or exemption is at issue?
  - Will the potential transaction jeopardize the CON authorization or exemption? Does the answer depend on the type of transaction (assets v. equity)?
  - Is prior approval/clarification required or prudent and how will it impact timing?

- CONs have value, which sometimes leads to disputes regarding who “holds” a CON

The Impact of CON Regulation

- CON may come with conditions/obligations (e.g., indigent & charity care commitment)

- There are penalties for non-compliance with the CON standards
  - Knowing development of a new institutional health service without a CON subject to fines of $5,000 per day up to 30 days, $10,000 per day from 31-60 days, and $25,000 per day after 60 days

- CON may be revoked for intentional provision of false information in CON application, failure to pay fines or moneys due DCH, or failure to maintain quality standards developed by DCH
Validity of a CON

- A CON is only valid for the defined scope, location, cost, service area, and person named in an application.

- A CON may not be transferred or assigned.

- However, the purchaser of existing health care facility that holds a valid CON acquires the CON as approved by the Department.

CON Reviewable Activities
“New Institutional Health Service”

- In Georgia, the term includes the “construction or other establishment of a new health care facility”
  - General Acute Care Hospital
  - Psychiatric or Specialty Hospital
  - Long Term Care Hospital
  - Ambulatory Surgery Center (unless exempt)
  - Skilled Nursing Facility / Intermediate Care Facility
  - Rehabilitation Hospital

“New Institutional Health Service”

- The term also includes clinical health services not offered during the previous 12 months
  - Pediatric Cardiac Catheterization
  - Adult Diagnostic Cardiac Catheterization (although exempt in hospitals)
  - Angioplasty (although may be exempt)
  - Open Heart Surgery
  - Obstetrical and Perinatal Services
  - Inpatient Psychiatric and Substance Abuse Services
  - Home Health Services
  - Comprehensive Inpatient Physical Rehabilitation
  - Positron Emission Tomography
  - MegaVoltage Radiation Therapy
New Institutional Health Service

- Expansions & upgrades are generally reviewable as a “NIHS” or under Service-Specific Rules. For example:
  - Increase in bed capacity (unless exempt)
  - Conversion or upgrade to a specialty hospital
  - Conversion from a non-reviewable facility to a reviewable facility
  - Increasing perinatal service level (e.g., adding NICU)
  - Adding OB beds or bassinets
  - Adding new counties for Home Health Services
  - Adding operating rooms (depending on cost, type, location)
  - Purchasing an additional Linear Accelerator

The 12–Month Rule

- Clinical health services that are offered in or through a health care facility, which were not “offered” on a regular basis in or through such health care facility within the twelve (12) month period prior to the time such services would be offered is a new institutional health service.
  - Open for acceptance of patients or performance of services
  - Has qualified personnel, equipment and supplies necessary to provide specified clinical health services
“New Institutional Health Service”

- Unless specifically exempted, any expenditure by or on behalf of a health care facility in excess of $3,068,601 (adjusted annually) is an “NIHS”
- Any expenditure to acquire medical equipment by a health care facility or any other party (except a freestanding imaging center) in excess of $1,324,921 (adjusted annually)
- Any expenditure to acquire equipment by a freestanding imaging center, regardless of amount

Expenditures Threshold Considerations (Equipment)

<table>
<thead>
<tr>
<th>Value Does Not Include:</th>
<th>Value Must Include:</th>
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<tbody>
<tr>
<td>“build out costs,” which are defined to include expenditures related to electrical, plumbing, masonry, modular buildings, renovation, new construction, or administrative space unrelated to the functionality of the equipment</td>
<td>operator training</td>
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<td>warranty for first five years</td>
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<td>transportation and insurance</td>
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<td>functionally related diagnostic or therapeutic equipment</td>
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<td>options, extra packages, and accessories</td>
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<td>first-five-years’ service contract</td>
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<td>volume or bulk purchase discounts</td>
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Expenditures Threshold Considerations

- Includes “items or services that are associated with and simultaneously developed or proposed”
- “Share a relationship or association based on law, regulation, function, procedure or process”
- Equipment is used for “same or similar” health services
- Expenses that occur within a 6-month period calculated from operation of the activity or service to second expenditure or operation of the second activity or service
- Does not include expenses outside the 6-month window

STATUTORY CON EXEMPTIONS
Replacement Equipment Exemption

- The replacement of CON-approved or grandfathered equipment regardless of cost is exempt if:
  - the replaced equipment will be removed entirely from the premises (although there are provisions to maintain minimal functionality)
  - the replacement equipment will be located in the same defined location as the replaced equipment
  - the replacement equipment offers a comparable or similar functionality and is used for the same diagnostic or treatment purposes

Replacement Equipment for Certain Freestanding Imaging Centers

- Except in rural counties, existing freestanding imaging centers that obtained an LNR may spend less than $870,000 for repair or replacement of equipment without obtaining a new CON
Physician-Owned, Single Specialty Ambulatory Surgery Centers

- Can be constructed, developed, and established for up to $3,068,601 (adjusted annually) OR
- Must have two or fewer operating rooms AND only one per practice in each county AND
- Must have a hospital affiliation agreement AND
- Must provide 2% indigent and charity care if participates in Medicaid; if the facility will not participate in Medicaid, if must provide 4% indigent and charity care AND
- Must provide annual reports to DCH
- NOTE: Can include general surgeons (and ortho/hand/physiatrists)
- NOTE: Can be owned 15% by non-physicians

Joint Venture Ambulatory Surgery Centers

- Joint venture ASCs between a single hospital and a single physician or a single specialty group of physicians will not require a CON if the ASC:
  - Will be located in the hospital’s county or in a contiguous county if no hospital is located in the contiguous county
  - Will be owned between 30-70% by the single hospital with the remainder owned by a single physician or a single group practice of physicians (physician(s) must own 30% and may own up to 70%)
  - Will be constructed, developed and established for less than $6,137,201 (adjusted annually beginning in July 2009) (six month period for additional expenditures)
  - Commits to provide 2% indigent and charity care if it will participate in Medicaid or, in the alternative, if the ASC will not participate in Medicaid, it must commit to provide 4% indigent and charity care
  - Commits to provide annual reports to DCH (i.e., surveys)
Joint Venture Ambulatory Surgery Centers (Continued)

- The single specialty physician or group practice may consist of general surgeons
- There is no limit on the number of operating rooms

Therapeutic Cardiac Catheterization

- Hospitals that already offer diagnostic cardiac catheterization may seek exemption determination to offer therapeutic catheterizations if they can document that the service meets standards developed by the Department
  - Detailed requirements, including volume projections, contained on DET Form
  - Ability to offer service will be reevaluated annually (May 1 – May 15th DET filing requirement)
  - Therapeutic caths will continue to be regulated by DCH under licensure standards to be developed in the future, with an emphasis on quality
Non-Clinical Projects Exemption

- Expenditures for non-clinical projects, including parking areas, computer systems, software, other information technology and medical office buildings, are exempt
  - Expenditures for such projects can exceed $3,068,601 and still be exempt
  - DCH interprets exemption such that other non-clinical projects, such as gift shops, physical plant repair, renovation to kitchen and laundry areas, etc. are not exempt

Relocation Exemption

- Healthcare facilities, including hospitals and ambulatory surgery centers may relocate without obtaining a new CON:
  - Any SNF or ICF within the same county (& may divide beds)
  - Any other healthcare facility in an urban county (> 35,000) within a 3-mile radius of the existing facility even if the new location is in another county
  - Any health care facility in a rural county within the same county
  - In order to qualify for the exemption, the healthcare facility may not offer new clinical health services that were not offered in the original location and may not expand existing clinical health services
Exemption for Increases in Bed Capacity

- A hospital may apply for an exemption to increase its medical-surgical bed capacity by up to ten beds or ten percent, whichever is greater if:
  - the hospital's existing beds have attained a 75% utilization over the previous 12 month period; and
  - the hospital has not increased its capacity in the prior 2 year period

Other Miscellaneous Exemptions

- Expenditures for the acquisition of an existing health care facility (unless owned or operated by or on behalf of state actors)
- Offices of private physicians or dentists except cath labs, radiation therapy, lithotripsy or certain ASCs
- Educational or Business Infirmaries
- Infirmaries offered by or on behalf of Dept. of Corrections for sole purpose of providing services to prisoners
- Costs to prepare CONs, acquire sites, or commitment of funds conditioned on CON approval
- Capital expenditures required solely to eliminate or prevent safety hazards or licensure or accreditation standards
- Services offered by or on behalf of an HMO
CON EVALUATION

General Review Considerations

- Consistency with the State Health Plan
- Need
- Existing alternatives are neither currently available, implemented, similarly utilized nor capable of providing a less costly alternative
- Financial Feasibility
- Effects on payors are not unreasonable
- Costs are reasonable and adequate for quality care
- Financial accessibility
- Positive relationship with existing health care delivery system

- Encourages efficient utilization
- Providing services to out of area residents
- Fosters research
- Meets the needs of clinical training programs
- Fosters improvements and innovations, promotes quality
- Fosters the special needs of HMOs
- Meets minimum quality standards
- Ability to obtain necessary resources, including personnel
- Proposing to offer an underrepresented health service
Demonstrating Need for a Project

“The population residing in the area served, or to be served, by the new institutional health service has a need for such services.”

-- O.C.G.A. § 31-6-42(a)(2)

Regionalization of Certain Services

Neonatal Intermediate Care

Neonatal Intensive Care
Demonstrating Need for a Project

- Numeric Need Calculation for Certain Services
  - E.g., Open Heart: did existing cath lab generate 250 open heart procedures in each of past 2 years?

- Types of Service Specific Need Rules
  - Ambulatory Surgery
  - Perinatal Services
  - SNF
  - Home Health
  - Comprehensive Inpatient Rehabilitation Services
  - PET/CT services
  - Megavoltage Radiation Therapy
  - Psychiatric and Substance Abuse Inpatient Services

Need Projection: MegaVoltage Radiation Therapy

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<td>2016 Resident Population</td>
<td>1,396,351</td>
<td>2,611</td>
<td>1,373,124</td>
<td>1,232,506</td>
<td>1,332,506</td>
<td>1,322,506</td>
<td>1,312,506</td>
<td>1,302,506</td>
<td>1,292,506</td>
<td>1,282,506</td>
<td>1,272,506</td>
<td>1,262,506</td>
</tr>
</tbody>
</table>
Exceptions to Need

- High utilization of existing service
  - E.g., >80% utilization of perinatal service over most recent 2 years
  - E.g., Actual utilization of radiation therapy unit > 90% of optimal utilization over most recent 2 years
- “Atypical barrier to care” based on cost, geographic or financial access or quality

CON APPLICATION AND REVIEW PROCESS
**Publication of Notice** (2 times per year)
- 30 Days

**Submission of Notice of Intent**
- 30 Days

**Submission of Application**

- **180 day application process** (no extensions permitted)
- Applicable to Applications for Home Health, Skilled Nursing, Open Heart, Pediatric Cardiac Cath, Perinatal, OB, Freestanding Birthing Centers, Psych / Substance Abuse, Comprehensive Inpatient Rehab, ASC, PET, and Megavoltage Radiation Therapy
- Applications Must Be Submitted Only at Two Pre-Set Times Each Year

**Batching Review Process**

- **Meeting with Applicant / Opposition Form Must be Submitted**
  - 60 Days

- **Additional Information Due**
  - 75 Days

- **Opposition Meeting and Submission of Substantive Written Opposition**
  - 90 Days

- **Letters of Support Due**
  - 100 Days

- **Amendment and Response to Opposition Due**
  - 110 Days

- **Decision Issued**
  - 120 Days

**Batching Schedule**

- **Fall/Spring** (HHA, SNF, ICF, Perinatal, Inpatient Rehab and Amb/Surg)
  - September // March
  - October // April
  - November // May
  - January // July
  - February // August
  - March // September
  - Batching Notice
  - LOIs Due (5 p.m. deadline)
  - CONs Filed (12 p.m. deadline)
  - 60 day Meetings & Notice of Opp. Due
  - Opposition Meeting
  - Decision

- **Winter/Summer** (PET, MVRT, OHS, Psych/SA, Birthing Centers)
  - December // June
  - January // July
  - February // August
  - April // October
  - May // November
  - June // December
  - Batching Notice
  - LOIs Due (5 p.m. deadline)
  - CONs Filed (12 p.m. deadline)
  - 60 day Meetings & Notice of Opp. Due
  - Opposition Meeting
  - Decision
NON-BATCHED REVIEW PROCESS

Submission of Notice of Intent
30 Days

Submission of Application
10 Business Days

Review for Completeness

- Application and review process ranges from 162 days to 194 days
- Applicable to All Non-Batched Applications including reviewable Non-Clinical Projects and projects over applicable expenditure thresholds
- Applications May Be Submitted at Any Time

Meeting with Applicant / Opposition Form Must be Submitted
60 Days

Additional Information Due
75 Days

Opposition Meeting and Submission of Substantive Written Opposition
90 Days

Letters of Support Due
100 Days

Amendment and Response to Opposition Due
110 Days

Decision Issued
120 / 150 Days

Notice of Intent

The Notice of Intent to apply must include:

- name and address of applicant;
- contact person;
- facility name and address;
- proposed site location;
- brief summary of proposed project;
- proposed service area; and
- estimated cost of the project

Application must be submitted on exactly the thirtieth day after the Notice of Intent was submitted (unless falls on weekend or holiday)
Opposition Meetings

• A single representative from each opponent must present the reasons for opposition to the Department at the meeting.

• Applicants are not allowed to speak at the Opposition Meeting but may attend.

• In order to have standing to appeal, opposing parties must participate in the Opposition Meeting.
The parties who have standing to appeal the Department’s CON Decision are limited to:

- The Applicant (if denied)
- Any competing (joined or batched) applicant
- Any competing healthcare facility that:
  - notified the Department of its opposition;
  - attended an opposition meeting; and
  - is aggrieved by the Decision
- Any county or municipal government in whose boundaries the proposed project will be located

The Chair of the Appeal Panel is responsible for determining whether a party has standing, which is construed broadly.
**Administrative Appeals Process Considerations**

- Appeals go before the Certificate of Need Appeal Panel, an independent body composed of up to 5 hearing officers appointed by the Governor for four-year term (2 vacancies remain)
- $1,500 filing fee must be paid with appeal request
- First administrative appeal is *de novo* and is heard by a hearing officer randomly assigned by the Chair of the Appeal Panel

**Scope of Administrative Appeal Hearing**

- The issues to be decided by the hearing officer are limited to the following:
  - whether the application is consistent with the review considerations
  - whether the Department committed prejudicial procedural error in the consideration of the application
  - whether the appeal lacks substantial justification
  - whether the appeal was undertaken primarily for the purpose of delay or harassment
- The hearing officer is precluded from determining whether the Department’s rules are correct, adequate, or appropriate
The hearing officer’s decision may be appealed by filing "specific objections" to the Department’s Commissioner within 30 days of the date of the hearing officer’s decision.

There is no express statutory or regulatory timeframe for the DCH Commissioner (or the Commissioner’s designee) to issue a decision, but once interpreted to be 60 days from decision.

The Commissioner is not required to hold a further hearing or hear oral arguments.

Findings of fact accepted unless lack of “any competent substantial evidence”.

Interpretation subject to “reasonableness” standard.

### JUDICIAL APPEALS PROCESS

- **DCH Commissioner Decision Issued**
  - 30 Days
  - Submission of Petition for Judicial Review
    - 150 days (Unless Extended to a Date Certain)
  - Hearing Held in Superior Court
    - 180 days
  - Superior Court Decision Issued

  - Appeal to Court of Appeals
    - No Timeframe Specified
  - Appeal to Georgia Supreme Court
    - No Timeframe Specified

- Superior Court petitions must be heard within four months of receipt and the Court must issue a decision within 30 days of the hearing.

- A losing petitioner must pay all attorneys’ fees and court costs (with some exceptions).
• Any party to an appeal, except the Department, may seek judicial review of the Commissioner’s decision
  • The Petition must be brought either in Fulton County or the County of Residence of the appellant
  • The Petition must be sought within 30 days of the Commissioner’s decision
  • Any Appellant whose Petition fails to prevail must pay all costs and attorney’s fees

• The superior court may reverse or modify the Commissioner’s decision only if the Department’s final decision is:
  • in violation of constitutional or statutory provisions
  • in excess of the statutory authority of the Department
  • made upon unlawful procedures
  • affected by other error of law
  • not supported by substantial evidence (in excess of “any evidence”)
  • arbitrary and capricious

• Strong precedent that the Court is to defer to the Department’s final decision
Further Judicial Review

The Superior Court’s decision must hold a hearing or issue a decision within 120 days of docketing of the Petition or the Department’s final decision is affirmed by operation of law.

A decision of the Superior Court may be reviewed by the Court of Appeals or the Supreme Court of Georgia.
Exemption Determinations (DET)

“Any person proposing an activity that would make it a health care facility unless exempted from prior CON review and approval…shall be required…to submit a request for a letter of determination from the Department…A party is not authorized to commence or undertake the activity in question which it believes falls within any one or more of the statutory exemptions in O.C.G.A. § 31-6-47 until written approval is issued by the Department…”

• Capital Expenditures v. Statutory Exemptions

Exemption Determinations (DET)

• The Department requires a $250 fee and the submission of a determination request form

• Opposition must be filed within 30 days of DCH receipt of request

• The Department’s rules do not mandate a timeframe for response to such determination requests

• No formal process for expedited requests
Letters of Non-Reviewability (LNR)

- Applicable to equipment expenditures and the development of single specialty ambulatory surgery centers (physician owned or joint venture)
- Detailed form for equipment LNR requests
- Requests for LNR must be submitted with a $500 request fee
- Opposition must be filed within 30 days of DCH receipt of LNR request

Appeal of LNRs and DETs

- Requesting party may appeal negative determination to Commissioner or her designee within 30 days
- Opposing parties have the right to request a “fair hearing” if the Department issues favorable determination as long as the party properly opposed the request
- Appeals subject to same Judicial Review procedures as CONs
• Projects that do not involve construction or equipment are effective for 12 months. (E.g., conversion of observation beds to inpatient beds)

• Projects that solely involve the acquisition of equipment are effective for 12 months, by which time the applicant must be in possession of equipment.

• Projects that involve construction are effective based on a schedule set forth in the application. However, for construction projects, an applicant must satisfy the “initial performance requirements” within the first 12 months:
  • construction plans approved by State
  • construction contract signed (with start and end dates)
  • construction materials and equipment are on site

• Extensions may be granted due to “circumstances beyond control”
The Department will fine and/or revoke certificates of need if health care facilities do not comply with requirements to submit annual and periodic reports and surveys:

- If surveys are late or incomplete, the Department may levy a fine of up to $500 per day for the first 30 days and $1,000 per day for every day over thirty days that the surveys are past due or incomplete.
- In addition to levying fines, the Department may revoke a health care facility’s CONs if surveys are not submitted in a complete and accurate fashion within 180 days of the due date.
- CON applications may be rejected for failure to complete surveys (including with batched projects).
11:00  THE CRIMINAL SIDE OF HEALTHCARE LAW
Brian F. McEvoy, Polsinelli PC, Atlanta
11:30  HOSPITAL MEDICAL STAFF ISSUES
Rod G. Meadows
John W. Ray, Ray & Gregory LLC, Atlanta
**MEDICAL STAFF**

*Original Chapter By*
Robert L. Porter Jr.

*2010 Update By*
Rod G. Meadows
Eric W. Littlefield
Meadows & Macie, P.C.
Stockbridge, Georgia

*2016 Update By*
Rod G. Meadows
Katherine C. Thompson
Meadows, Macie & Sutton, P.C.
Stockbridge, Georgia

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MEDICAL STAFF

I. INTRODUCTION

The consolidation of hospitals and healthcare systems, and the corresponding increased employment and affiliation of physicians and physician groups with such entities, have changed the traditional relationship between physicians and hospitals in many practical ways. Issues including physician competence and behavior can now often be addressed through contract and/or employment law, rather than traditional medical staff procedures. Nonetheless, there are still independent physicians and institutions—and situations within complex healthcare institutions—for which the traditional relationship between these entities remains extremely important.

The organizational structure of the traditional American hospital is different from most business organizations where there is a final authority which has the power to exercise control over all facets of the entity’s business operations, including those affecting its financial well-being and the quality of its products and services. The hospital structure encompasses a division of control between three groups: a Governing Body, Hospital Management, and a “self-governing” Medical Staff which is comprised of physicians practicing medicine in the hospital. Under this system, Management and the Governing Body control most of the cost centers of a hospital, including determining the facilities and types of services available, while the Medical Staff in many ways controls the demand for medical services (and thus the revenue available to the hospital) as well the quality of professional medical services rendered in the hospital.

The complex relationships between the Governing Body, the Management, and the Medical Staff, in addition to the relationships between the Medical Staff and individual physicians, have long been the source of disputes and litigation as each of the actors seek to protect their own interests and to accommodate the interests of others. The likelihood and frequency of disputes and litigation is further increased by: (1) changes in legal doctrine concerning the corporate liability of hospitals for the negligent acts of physicians practicing within the hospital; (2) changes in the economic climate of the healthcare industry, including programs adopted by government, private industry and insurance companies to control healthcare costs, which have created differing economic incentives and disincentives for the hospital and the physician; and (3) changes in the mutual need of the hospital and the physicians for access to, and the services of, the other based upon the increasing importance to physicians of access to health care technologies and facilities only available in hospitals, and the increasing competition among hospitals to secure a quality Medical Staff, including specialties.

This chapter begins with an overview of the traditional organization known as the Medical Staff, its relationship to the hospital and the legal and regulatory background setting the parameters of such organization. The chapter will then turn to an overview of the laws and regulations related to the duties of the hospital corporation to regulate its Medical Staff, the means by which such regulation is exercised and limitations placed by constitutional and legal principles upon the hospital’s exercise of authority over members of the Medical Staff.
II. ORGANIZATION

A. Organizational Requirements

The present structure of the Medical Staff organization, and the respective functions and interactions of the Medical Staff and the Governing Body, were dictated, in many respects, by the standards of hospital accreditation formulated by three separate sources of authority: the Joint Commission, Medicare (via the Conditions of Participation), and state licensure law. In fact, the Joint Commission standards are so universally accepted that, prior to July 15, 2010, a Joint Commission accredited hospital would have been deemed to qualify for participation in the Medicare program and, in Georgia, Joint Commission accreditation can be accepted by the Georgia Department of Human Resources as evidence of compliance with the Department’s licensure standards. Accordingly a logical approach to understanding the subject is to first review the Joint Commission standards descriptive of the Medical Staff organization.

1. The Joint Commission Standards

Under the Joint Commission standards, each accredited hospital must have a single, organized, self-governing Medical Staff. The Medical Staff must be accountable to the Governing Body and must have responsibility for the quality of the professional services provided by individuals with clinical privileges. The Medical Staff must be composed of licensed physicians and may also include others permitted by law and the hospital to provide patient care services independently in the hospital. Mechanisms must be developed for the appointment and reappointment of Medical Staff members and the granting, renewal and revision of clinical privileges for such members. These mechanisms must include the granting of staff membership and privileges by the final decision of the Governing Body, but only upon the recommendation of the Medical Staff based upon criteria specified in the Medical Staff bylaws which must be uniformly applied to each applicant or staff member and which are designed generally to insure quality patient care.

The Joint Commission standards dictate that the Medical Staff must formulate and adopt bylaws, rules and regulations to establish a framework for self-governance of Medical Staff activities and accountability to the Governing Body. These bylaws must be adopted by the Medical Staff and approved by the Governing Body. The bylaws may not be unilaterally amended by either body.

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1See 42 U.S.C.A. § 1395bb prior to July 15, 2008. A new statute signed into law on July 15, 2008 removed the statutory reference to the Joint Commission, effective July 15, 2010. This means that the Joint Commission will have to apply for deemed status and be approved by the federal government.
2O.C.G.A. § 31-7-3(b).
4Id. at MS.2.1 – 2.4.
5Id.
6Id. at MS.1.
7Id. at MS.01.01.03.
The Medical Staff must have officers, each of whom must be a Staff member. In addition, the Medical Staff must have a Medical Executive Committee ("MEC") with the authority to make recommendations directly to the Governing Body for its approval and which pertain to Medical Staff structure, credentialing and the delineation of clinical privileges, recommendation of individuals for staff membership and of delineated clinical privileges for such individuals, participation of the Medical Staff in the organization's performance improvement activities, mechanisms for the termination of Medical Staff membership and mechanisms for fair hearing procedures. The Medical Staff must have a leadership role in performance-improvement activities when the performance of an activity is dependent primarily on individuals with clinical privileges and must participate in other patient care processes. When the activities relate to the Medical Staff (or individuals with clinical privileges) the processes in which the Medical Staff provides leadership must include medical assessment and treatment of patients, use of medications, use of blood and blood components, use of operative and other procedures, the efficiency of practice patterns and significant departures from established patterns of clinical practice. In this connection the Medical Staff must determine the use of performance-improvement process findings relevant to individual performance of persons with clinical privileges in the peer review process in accordance with standards on renewing or revising clinical privileges.

Besides requiring a substantially independent, self-governing Medical Staff, the Joint Commission further requires that the Governing Body receive direct input from the Medical Staff by affording representatives selected by the Medical Staff the right to attend and speak at Governing Body meetings. Unless legally prohibited, Medical Staff members must also be eligible to be members of the Governing Body. The Joint Commission has previously stated that the intent for these standards is to permit the Medical Staff, through its participation in governance, to ensure that all Medical Staff members are clinically competent and that appropriate care is rendered and to allow the Medical Staff to contribute to the organization's planning, budgeting, safety management and overall performance-improvement activities.

2. Medicare Conditions of Participation and the Joint Commission "Deemed" Status

A second source of legal criteria prescribing the general structure of a hospital and its Medical Staff is found in the Medicare Conditions of Participation. The Joint Commission standards have been so influential that prior

8Id. at MS.01.01.01.
9Id. at MS.02.01.01.
10Id. at MS.03.01.01; MS.05.10.10.
11Id. at MS.05.01.01.
12Id. at MS.05.01.03; MS.06.01.01.
13Id. at LD.01.03.01.
14Id. at LD.01.01.01.
1642 C.F.R. § 482.
to July 15, 2010, Congress had determined Joint Commission accreditation to be sufficient to “deem” a hospital in compliance with the Conditions of Participation.\textsuperscript{17} That “deemed” status has recently come under fire, and on July 15, 2008 a new statute was signed into law that removed the statutory reference to the Joint Commission. Under a transition provision in that new law, the Joint Commission’s “deeming authority” ended on July 15, 2010. Prior to that date, CMS accepted a hospital’s evidence of Joint Commission accreditation as sufficient for Medicare deemed status. Under the new statute, the Joint Commission will have to reapply for its “deeming” privileges. In any event, even after July 15, 2010, a hospital whose participation was based on Joint Commission accreditation issued prior to July 15, 2010 will continue to participate in Medicare via deemed status until the normal expiration of its accreditation.

Since most hospitals are accredited, few hospitals become directly concerned with the specific requirements of the federal regulations, however, those who do will find the regulations very similar to the Joint Commission standards. The regulations describe the hospital/Medical Staff structure and relationship by imposing upon the hospital conditions of participation applicable to the Governing Body and to the Medical Staff. Each hospital must have a Governing Body which is legally responsible for the conduct of the hospital and which, with respect to the Medical Staff, has responsibility for determining categories of practitioners eligible for membership in the Medical Staff, making appointments to the Medical Staff based upon recommendations of the existing Medical Staff members, exercising the right of approval of the Medical Staff’s bylaws and rules and regulations, insuring that the Medical Staff is accountable to the Governing Body for the quality of care provided to patients and assuring that the criteria for staff membership are the individual’s character, confidence, training, experience and judgment, and not dependent solely upon certification, fellowship or membership in a specialty body or society.\textsuperscript{18}

Under the Conditions of Participation, the Medical Staff must be organized and must operate under bylaws approved by the Governing Body and must be responsible for the quality of medical care provided for patients in the hospital. The Medical Staff must be composed of physicians and other practitioners permitted by state law, must periodically conduct appraisals of its members, and must examine the credentials of applicants and make recommendations on appointment of members to the Governing Body. The Medical Staff bylaws must describe the duties and privileges of staff members and other various categories of staff membership, the organization of the Medical Staff, the qualifications for Medical Staff membership and the criteria for determining and granting clinical privileges.\textsuperscript{19} Although the foregoing Conditions of Participation are much less detailed than the Joint Commission standards, the basic organizational structure required by them for the hospital, Governing Body, and the Medical Staff are the same.

\textsuperscript{17}See 42 U.S.C.A. § 1395bb, prior to July 15, 2008 amendment.
\textsuperscript{18}42 C.F.R. § 482.12.
\textsuperscript{19}42 C.F.R. § 482.22.
3. **State Licensure**

Until July 1, 2012, Georgia’s hospital licensure scheme fell in line with both the Joint Commission standards and the Medicare Conditions of Participation. In 2012, the General Assembly passed Senate Bill 361 and amended O.C.G.A. § 31-7-3(b) which allowed the Department of Community Health to broaden the types of certification or accreditation bodies which demonstrate an institution’s compliance with the Department’s requirements for the issuance of a permit in Georgia. It should be noted, however, that the Joint Commission still has considerable influence, through case law, regarding the policies and procedures of an institution, particularly as they relate to medical staffing issues. The Regulations promulgated by the Department of Community Health (which are also similar to the Joint Commission and the Medicare Conditions) require that each hospital be under the control of a Governing Body, that the professional staff providing service to patients in the hospital be appointed by the Governing Body, and that the professional staff be organized under bylaws approved by the Governing Body and be responsible to the Governing Body for the quality of all medical care to patients in the hospital and for the ethical and professional practices of staff members.

**B. Legal Status of the Medical Staff**

Although the organized Medical Staff form has been in existence since the early part of last century, debate has arisen over whether the Medical Staff is a legal entity apart from the hospital corporation. Until 1975, the uniform view was that a Medical Staff was merely a division or unit of a hospital whose power and functions flowed from the Governing Body which bears the ultimate legal responsibility for the actions of the Medical Staff.

In 1975, a New Jersey court allowed a medical malpractice action to proceed against a Medical Staff based upon allegations that the Medical Staff negligently investigated the credentials of a physician who later injured the plaintiff upon a finding that the Medical Staff was an unincorporated association amenable to suit. A year later, the South Dakota Supreme Court allowed a Medical Staff to sue its hospital to challenge bylaw amendments adopted unilaterally by the hospital’s Governing Body upon a finding that the Medical Staff was an unincorporated association capable of suing. Neither of these cases presented a reasoned explanation of their holding. On the other hand, Colorado and Wisconsin courts each adopted the view that the Medical Staff was a part of the hospital corporation, subordinate to and an arm of the Governing Body.

Federal circuit court decisions in the antitrust area have produced sharp disagreement over whether a Medical Staff is a separate legal entity capable of conspiring with the hospital in violation of the antitrust laws. The Eleventh and Ninth Circuits have

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20 O.C.G.A. § 31-7-3(b).
21 42 C.F.R. § 482 et seq.
24 St. John’s Hospital Medical Staff v. St. John Regional Medical Center, 245 N.W.2d 472 (S.D. 1976).
25 Ad Hoc Executive Committee v. Runyan, 716 P.2d 465 (Colo. 1986); Johnson v. Misercordia Community Hospital, 294 N.W.2d 501, aff’d, 301 N.W.2d 156 (Wis. 1981).
found that it is. The opposite view has been taken by the Third, Fourth and Sixth Circuits.

In Ramey v. Hospital Authority of Habersham County, the Georgia Court of Appeals considered a claim asserted by a plaintiff in a medical malpractice case that the Medical Staff was an unincorporated association amenable to suit. The trial court agreed with the plaintiff on that issue but dismissed the Medical Staff on charitable immunity grounds. On appeal, the Court of Appeals affirmed the dismissal but on the grounds that the Medical Staff was not a separate, independent entity capable of being sued. In reaching its conclusion, the court relied upon: the relationship of the Governing Body and Medical Staff of a hospital as described in the hospital licensure rules and regulations as promulgated by the Georgia Department of Human Resources; established law which made the Governing Body of the hospital responsible and liable for Medical Staff appointments; and bylaw provisions of the hospital authority in question which specifically stated that the Medical Staff was an integral part of the medical center and not a separate legal entity.

One commentator has made a persuasive argument that the traditional view of a Medical Staff as a mere division or unit of a hospital lacking separate legal status is correct because the Medical Staff lacks ultimate control over its membership, bylaws, rules, regulations, and internal discipline; all of which are subordinate to the Governing Body. The Georgia Court of Appeals decision in Ramey follows the same principles. In contrast, courts in North Carolina have taken the opposite view. In Virmani v. Presbyterian Health Services Corp., the Court of Appeals of North Carolina determined that a Medical Staff is a distinct legal entity, capable of entering into legally enforceable agreements. The court also determined that Medical Staff bylaws are a contract between the Staff and the hospital. This decision has enabled Staff member physicians in North Carolina to bring suit against a hospital for breach of contract where the hospital or the Medical Staff (as an entity) fails to abide by the terms of the bylaws.

C. Bylaws

The adoption of bylaws to govern the Medical Staff are a requirement of state licensure, participation in the Medicare Program, and the Joint Commission standards. As in other areas of hospital organization, the principal source of influence over the contents of Medical Staff bylaws is found in the Joint Commission standards. These standards require that bylaws provide at least the following: (1) an MEC with power to act

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26 Bolt v. Halifax Hospital Medical Center, 851 F.2d 1273 (11th Cir. 1988), vacated, 861 F.2d 1233 (11th Cir. 1989), reinstated in part, 874 F.2d 755 (11th Cir. 1989) (en banc), after remand, 891 F.2d 810 (11th Cir. 1990), cert. denied, 495 U.S. 924, 110 S.Ct. 1960 (1990); Oltz v. St. Peter’s Community Hospital, 861 F.2d 1440 (9th Cir. 1988).
27 Oksanen v. Page Memorial Hospital, 945 F.2d 696 (4th Cir. 1991) (en banc), cert denied, 112 S.Ct. 973 (1992); Weiss v. York Hospital, 745 F.2d 786 (3d Cir. 1984), cert. denied, 470 U.S. 1060 (1985); Nanavati v. Burdette Tomlin Memorial Hospital, 857 F.2d 96 (3rd Cir. 1988); Potters Medical Center v. City Hospital Ass’n, 800 F.2d 568 (6th Cir. 1986).
29 Nodzenski, supra, at 595-598.
31 Id.
32 See also Lohrmann v. Iredell Memorial Hospital Incorporated, 174 N.C. App. 63 (2005).
33 GA. COMP. R. & REGS 111-8-40.11 (2013); 42 C.F.R. §§ 482.12 and 482.22; and Joint Commission, Manual, MS.01.01.01.
between staff meetings and related provisions describing its function, size and composition; (2) fair hearing and appellate review mechanisms for members of the Staff and applicants for membership; (3) mechanisms for corrective action including indications and procedures for the automatic and summary suspension of Staff membership or privileges; (4) a description of the Medical Staff organization, including officers and staff categories; (5) the method of selection, qualification, duties and tenures of officers together with provisions for removal; (6) requirements for frequencies of meetings and attendance; (7) mechanisms to assure effective communication among the Medical Staff, hospital administration and the Governing Body; (8) mechanisms for adopting and amending the Medical Staff bylaws, rules, regulations, and policies, and (9) Medical Staff representation and participation in any hospital deliberation affecting Medical Staff responsibilities.34

Beginning in the 1990’s, many hospitals began setting forth detailed provisions for credentialing and “fair hearings” in their policies and procedures (which were generally more easily amended than the Medical Staff bylaws). Over a lengthy, and sometimes contentious course, the Joint Commission adopted what is currently referred to as MS 01.01.01 which specifies those provisions which must be contained with the policies and procedures and the basic requirements which must be set forth in the Medical Staff bylaws.35

In formulating the provisions of the bylaws specifying the required fair hearing and appellate review procedures, consideration should be given to the provisions of the Health Care Quality and Improvement Act of 1986.36 The Act provides, in part, for limited immunity from damages for the benefit of participants in a professional review action if certain requirements are met, which include the requirement of adequate notice and hearing procedures.37 In particular, notice and hearing procedures are deemed to be adequate with respect to a physician if specific “safe harbor” provisions outlined in the Act are afforded the accused physician.38 Although the notice and hearing procedures specified in the Act may exceed the constitutional requirements of due process as determined by the courts, the availability of the Act’s immunity provisions makes conformity to the Act’s notice and hearing procedures worthwhile, if not for the actual defense of a potential claim by an aggrieved physician, then for the purpose of encouraging Medical Staff members to participate in professional review actions with less fear of personal liability.

III. REGULATION OF MEDICAL STAFF PRIVILEGES

A. Duty to Regulate: Quality Assurance

Under the statutory, regulatory and accreditation standards applicable to hospitals, there exists an institutional duty imposed upon the hospital Governing Body to maintain quality of patient care in the institution and, in fact, to endeavor to improve the level of care. Georgia hospitals are subject to a statutory duty to “provide for the review of professional practices in the hospital . . . for the purpose of reducing morbidity and mortality and for the improvement of the care of patients in the hospital” which review

34Joint Commission, Manual, MS.01.01.01.
35Id.
37 Discussed in detail in section III.E., below.
3842 U.S.C.A. § 11112(b).
must include “the evaluation of medical and health care services or the qualifications and professional competence of persons performing or seeking to perform such services.”

Similarly, the Joint Commission standards require the Governing Body to be responsible for maintaining quality patient care, and both the Medicare Conditions of Participation and existing Georgia licensure regulations require the Governing Body to provide for an organized Medical Staff which is to be accountable to the Governing Body for the quality of patient care.

Combined with the foregoing duties derived from statutory and regulatory sources has been the development of legal doctrines of corporate liability which have clearly established that the hospital may be held responsible for the negligent care by physicians of patients in the hospital where the hospital fails in its institutional duties to assure quality of care. In Darling v. Charleston Community Memorial Hospital, the case generally credited with establishing the doctrine of corporate liability of hospitals for medical malpractice, the court held that a hospital had a duty to insure the quality of care rendered at the institution and thus could be held responsible for failure to monitor the quality of care provided by a staff physician who was found incompetent to perform the procedures in question. The Georgia courts soon followed suit. Recognizing prior Georgia case law establishing the hospital’s right to limit a physician’s right to practice and to impose reasonable rules and regulations upon such practice, the Georgia Supreme Court, in Mitchell County Hospital Authority v. Joiner, held that, since a hospital has the duty to examine the credentials of any applicant seeking staff privileges and to limit the applicant’s practice to areas in which the applicant is qualified or even to bar the applicant from practice if found incompetent, unqualified, inexperienced or reckless, a breach of this duty was deemed independent negligence by the hospital for which it would be held responsible. The hospital’s argument that it should not be held responsible because it had relied upon the recommendation of its Medical Staff, and thus was not responsible for information in the possession of the Medical Staff, was rejected on the basis that the Medical Staff was acting as the hospital’s agent in evaluating the physician’s credentials and the delegation of such duty to the Medical Staff did not relieve the hospital of responsibility.

B. Mechanisms for Regulation

Having established that the hospital and its Governing Body have a legal responsibility to assure quality of patient care, we next turn to an examination of the established mechanisms through which this responsibility is carried out. It is in this context that the organizational precepts of hospitals and Medical Staffs make themselves felt most keenly. Following well established policies that physicians should not be subject to the

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39 O.C.G.A. § 31-7-15(a).
40 Joint Commission, Manual, LD.01.03.01.
42 Formerly, Georgia Rules and Regulations for Hospitals, § 290-9-7-.09.
control of laymen in the exercise of their professional judgment, the hospital’s Governing Body is expected to rely upon the Medical Staff to evaluate the qualifications of applicants for credentials, to monitor the care of existing staff members, and to initially review and act on staff members whose professional conduct requires corrective action. Although the final authority upon the issue of Medical Staff membership and credentials is the Governing Body, the Governing Body is not permitted to act without the recommendations of and consultation with the Medical Staff. Thus, the Governing Body, which has legal responsibility to the patient, has had to develop policies and practical procedures by which the Medical Staff can function to assure quality, with the Governing Body taking direct action on those occasions when issues of appointing, reappointing or disciplining Medical Staff members are presented to the Governing Body with the recommendation of the Medical Staff.

As in other areas of hospital organization, the commonly adopted mechanisms for quality assurance activities in hospitals substantially conform to the standards pronounced by the Joint Commission. Both the Governing Body and the Medical Staff are required to implement mechanisms to monitor and evaluate the quality of patient care including the clinical performance of staff members. When performance-improvement activities (mandated by the Joint Commission standards) lead to a conclusion that an individual with performance problems is unable or unwilling to improve, the organization is required to act to modify such person’s clinical privileges in accordance with the standards set out in the Joint Commission Manual. The principal methods by which the care given by staff members is controlled is by the granting and withholding of clinical privileges which are, in substance, the Governing Body’s permission to a particular staff member to provide medical services in the hospital. These privileges are to be limited to services which the Governing Body approves, upon the recommendation of the Medical Staff, which are based upon the physician’s licensure, relevant training or experience, current competence and ability to perform the privileges in question.

Staff appointments are required to be limited to periods of no more than two years with reappointment to be made based upon a reappraisal of the staff member at the time of reappointment and upon the staff member’s demonstrated current competence. Information derived from ongoing quality assessment and improvement activities at the hospital must be considered when available and, of course, such activities are required by the Joint Commission standards. Following a consideration by the Medical Staff of the pertinent information, the Medical Staff makes a recommendation to the Governing Body concerning the granting, denial or limitation of clinical privileges for new applicants and candidates for reappointment. Adverse recommendations by the Medical Staff or adverse decisions by the Governing Body must be subject to fair hearing and appellate review procedures.

46Joint Commission, Manual, LD.02.03.01.
47Id. at PI.04.01.01; MS.05.01.01.
48Id. at MS.06.01.01.
49Id. at MS.07.01.01.
50Id. at MS.05.01.03.
51Id. at MS.10.01.01.
C. Limits on the Power to Regulate

The duty of the Governing Body to assure the quality of care in the hospital, combined with the use of denials, limitations or revocations of clinical privileges as the principal means to enforce quality standards, has resulted in frequent conflict between hospitals and physicians. The importance of Staff privileges to a physician’s economic and professional success has almost assured that the imposition of limitations on the physician’s practice by denial, revocation or limitation of privileges by hospitals would result in legal challenges to the hospital’s exercise of its authority. We now turn to a review of the most common theories on which physicians have mounted such challenges.

1. Public Hospitals

(a) Constitutional Limits

In the case of public hospitals, including the Hospital Authorities created under Georgia law, the principal challenges to adverse Medical Staff privileges have been allegations of the deprivation of constitutional rights under the Due Process and Equal Protection Clauses of the Fifth and Fourteenth Amendments. It is now well established that the action of a public hospital and of its agents are state action subject to constitutional limitations.52

On the other hand, the actions of private hospitals have been held not to be “state action” under applicable principles. For example, a private non-profit hospital’s actions in terminating a physician’s staff privileges has been held by the Georgia Court of Appeals not to have a sufficient nexus between the State and such action as to constitute an act of the State.53

In recent years the prevalence of “restructured” Hospital Authorities has given rise to the question whether a non-profit corporation which is operating an Authority owned hospital under a lease agreement (a typical method of “restructuring”) is a state actor under applicable federal constitutional law.54 In Willis v. University Health Services, Inc.,55 the Eleventh Circuit considered the claim of a registered nurse who had filed an action under 42 U.S.C.A. §1983 alleging that her firing by the private non-profit hospital which operated a hospital under lease from a Georgia Hospital Authority violated her rights to free speech and due process. The court affirmed the decision of the district court dismissing the claim on the grounds that no state action was present to support the constitutional claims. In determining whether a claim could be maintained, the court recognized previous precedent holding that a private hospital could only be subject to

52Shaw v. Hospital Authority of Cobb County, 507 F.2d 625 (5th Cir. 1975); Silverstein v. Gwinnett Hospital Authority, 861 F.2d 1560 (11th Cir. 1988); Faucher v. Rodziewicz, 891 F.2d 864 (11th Cir. 1990); Crosby v. Hospital Authority of Valdosta and Lowndes County, 93 F.3d 1515 (11th Cir. 1996).
54See Crosby, 93 F.3d 1515.
55993 F.2d 837 (11th Cir. 1993).
Section 1983 and the Fourteenth Amendment if its activities are significantly affected with state involvement. This state involvement will be found only if one of three tests are satisfied. These are (1) the public function test, (2) the state compulsion test or (3) the nexus/joint action test.

The public function test applies to instances where private actors are performing functions traditionally the exclusive province of the state. The court in Willis found (without much discussion) that University Health Services, Inc.’s operation of a hospital did not constitute the exercise of powers traditionally reserved to the state. The state compulsion test applies where the state government has coerced or at least significantly encouraged the act alleged to violate the Constitution. The court found that the Hospital Authority did not in any way coerce or even encourage University Health Services, Inc. to fire the plaintiff, therefore the second test was not met. These findings left the court to address the argument made by the plaintiff that the Hospital Authority and University Health Services, Inc. were so intertwined in a “symbiotic relationship” that they satisfied the nexus/joint action test. Recognizing that each “intertwining” case must be decided on its own facts, the court found the decision by the Fifth Circuit in Greco v. Orange Memorial Hospital Corp.,56 persuasive. The court stated:

Similarly, in this case, the lease obligates UHS to serve the general public, including indigent patients, and to provide the auditor with a financial report. Most importantly, however, the lease relinquishes RCHA of all liabilities, gives UHS sole discretion to hire and fire employees, provides that UHS is the governing body of University Hospital and Medical Staff, mandates that UHS maintain and repair the leased properties at its own expense, requires UHS to maintain insurance, confers upon UHS the right and authority to make and enforce rules and regulations and safety considerations, and demands that UHS hold RCHA harmless from any court action. Thus UHS and RCHA are not so intertwined in a symbiotic relationship as to satisfy the nexus/joint action test.57

Once it is determined that state action is present, it is also necessary, in order for the acts of a public hospital to implicate the Due Process Clause, that those acts impinge upon a protected “liberty” or “property” interest. The starting point in the inquiry whether such a protected interest exists is the U.S. Supreme Court decision in Roth58 which held that in order to have a protected property interest: “a person clearly must have more than an abstract need or desire for it. He must have more than a unilateral

56513 F.2d 873 (5th Cir. 1975).
57Id. at 841.
58Board of Regents v. Roth, 408 U.S. 564 (1972).
expectation of it. He must, instead, have a legitimate claim of entitlement to it." Further, the Supreme Court held that no liberty interest was impacted unless the adverse action imposes a stigma or other disability that would impinge his freedom to obtain other employment opportunities or unless charges were made against him which might seriously damage his standing and associations in the community.

Does a physician have a legitimate claim of entitlement to Medical Staff privileges at a particular hospital? Although it may be acknowledged that a physician, by right of licensure alone, does not obtain the automatic right to practice at any public hospital, a review of the extensive protections afforded physician’s privileges under the Joint Commission standards, as commonly implemented in Medical Staff bylaws, leads one easily to the conclusion that the physician does indeed have such an interest. It is now accepted that, as a general proposition, a physician has a constitutionally protected property interest in continuation of Medical Staff privileges at a public hospital. It is also accepted, as a general proposition, that the right to seek Medical Staff privileges at a public hospital is a protected liberty interest.

Although the general propositions stated above are well settled, it is interesting to note that particular factual scenarios still give rise to difficulty in defining whether a constitutionally protected interest was impinged by a particular hospital action. For example, in Faucher v. Rodziewicz, the Eleventh Circuit held that no protected property or liberty interest was impacted when, without terminating or restricting a physician’s Medical Staff privileges, that hospital entered into a contract with another physician as medical director of the anesthesia department who then proceeded, pursuant to the contract, to institute administrative policies which substantially curtailed the first physician’s case load at the hospital. The reduction in economic value of the Medical Staff privileges to the physician due to the institution of the administrative policies did not rise to the level of a property interest. Nor was any liberty interest impinged where no termination or suspension of the physician’s privileges occurred and there was no proof of any stigma attaching by reason of the hospital’s action.

Even more fascinating is the Eleventh Circuit’s decision in Todorov v. DCH Healthcare Authority, which held that a hospital’s denial of the addition of radiology privileges for a neurologist did not implicate either a property or liberty interest deserving of protection. The court explained that a claim of entitlement implicating the due process clause required the support of a state statute, legal rule or a mutually explicit understanding.

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59Id. at 577.
60Yeargin v. Hamilton Memorial Hospital, 225 Ga. 661.
61Shahawy v. Harrison, 875 F.2d 1529 (11th Cir. 1989).
62Silverstein v. Gwinnett Hospital Authority, 861 F.2d 1560.
63Faucher, 891 F.2d 864; see also, Shahawy v. Harrison, 875 F.2d 1529; Bellam v. Clayton County Hospital Authority, 758 F. Supp. 1488 (N.D. Ga. 1990).
64921 F.2d 1465 (11th Cir. 1991).
Once a physician is granted privileges the protections of the Medical Staff bylaws create a right deserving of constitutional protection before the privileges can be taken away. However, no such right exists with respect to a physician’s request for additional privileges. The court distinguished past precedent requiring due process procedures in the initial denial of an application for Medical Staff membership as being based upon a finding that the total denial of staff privileges seriously limited a physician’s ability to engage in private practice while the denial of radiology privileges as an addition to existing neurology privileges did not seriously impair Dr. Todorov’s practice. The court further refused to find a protected liberty interest because such liberty interest can only be found when a person is stigmatized in connection with the denial of a right or status recognized by law. Since no legitimate claim of entitlement to the additional staff privileges was shown, no liberty interest could be implicated by their denial.

(b) Georgia Non-constitutional Limits

Pursuant to O.C.G.A. § 31-7-7, public hospitals in Georgia are required to act in a non-discriminatory manner, expeditiously and without unnecessary delay, upon the initial applications of licensed doctors of medicine, osteopathy, podiatry and dentistry. The decision is required to be made on the basis of the applicant’s demonstrated training, experience, competence and availability and reasonable objectives, including but not limited to the appropriate utilization of hospital facilities. Final action is required within ninety (90) days of receipt of the application except when the applicant is licensed by a government outside of the continental United States and then within one hundred twenty (120) days. It is important to recognize that this statute is expressly made applicable only to applications of persons holding the listed licenses who are not already members of the Medical Staff of the hospital and do not already have privileges to practice at the hospital.

The Georgia Court of Appeals, in St. Mary’s Hospital of Athens, Inc. v. Radiological Professional Corp. faced a challenge by a physician to the termination of his privileges by a private hospital which the physician alleged to have acted in violation of the hospital’s bylaws. In seeking to find a rationale to support a cause of action for this physician, the court reviewed past case law considering staff privileging decisions by public hospitals. Interpreting Georgia Supreme Court precedent as providing that, “although a physician has no absolute right to practice in a given public hospital, only a privilege, the physician is entitled to practice in the public hospitals as long as he complies with applicable laws, rules, and regulations, and such privileges may not be deprived by rules or acts that are

65St. Mary’s Hospital of Athens, Inc., v. Radiology Professional Corp., 205 Ga. App. 121; compare, Robles v. Humana Hospital Cartersville, 785 F. Supp. 989 (N.D. Ga. 1992) which was decided prior to the St. Mary’s decision and in which the district court found that, although the private hospital’s bylaws were not a contract supporting a claim for breach thereof, the private hospital would be required to follow its own bylaws with a violation to be remedied by an injunction.
reasonable, arbitrary, capricious, or discriminatory,” the Court of Appeals drew as logical the inference that “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.” The court held that, although a public hospital has broad authority to change its bylaws, it also follows that a legal duty exists as to public hospitals to follow the existing bylaws and that a violation of that duty is actionable in tort under O.C.G.A. § 51-1-6.

2. Private Hospitals

The traditional view has been that private hospitals are not subject to judicial review with respect to Medical Staff credentialing matters. As private institutions, no required state action is present to make applicable the constitutional safeguards discussed in reference to public hospitals. Although federal constitutional law has generally not been applied, a trend in decisions of courts in other states should be noted. In 1963 the New Jersey Supreme Court held that a private hospital served a public purpose which it was required to exercise reasonably and for the common good and, therefore, should be subject to judicial review. This, or similar theories, has been followed in other states as well, usually in cases involving private hospitals receiving large amounts of public funds or which had a monopoly in their geographic area. On the other hand, some states have rejected the rationale of these cases and left private hospitals to their own devices. Other states have imposed judicial review based on contract law theories by finding that a contractual relationship was created between members of the Medical Staff and the hospital through the terms and conditions of the Medical Staff bylaws.

Before 1992, no Georgia cases had considered imposing judicial review on a private hospital based upon such theories. In fact, in Todd v. Physicians & Surgeons Commercial Hospital, the Georgia Court of Appeals held that a private

60Id. 421 S.E.2d at 736-37 (citing Cobb County-Kennestone Hospital Authority v. Prince, 242 Ga. 139, 249 S.E.2d 581 (1978)).

hospital had no contractual obligation to a podiatrist on its Medical Staff which prevented it from amending its bylaws in a fashion which disqualified the physician from Staff membership. However, in the St. Mary’s decision, discussed above, the Georgia Court of Appeals considered several alternative arguments supporting a physician’s claim that he should have a cause of action against a private hospital which terminated his privileges in violation of its bylaws. The court rejected numerous theories including those of tortious infliction of emotional distress, tortious interference with contractual relations, deprivation of liberty or property rights without due process of law as well as an asserted breach of a contractual obligation to follow the bylaws. Its maintenance of the theory that the bylaws are not a contract as posited in Todd preserves the right of hospitals to change and amend bylaws without facing claims of breach of contract by physicians affected by the amendments. But finally, the court, noting that licensure law and regulations required all hospitals in Georgia, private as well as public, to have bylaws which include requirements for notice, hearing, and appellate review before termination of staff privileges, that public hospitals were required to follow such bylaws and were subject to judicial review, asked itself the question, “Does the same duty devolve upon private hospitals?” The court answered:

Since the issue is existence of a legal duty to follow procedures established pursuant to state law, not the presence of state action, we see no reason to distinguish between public and private hospitals in this context. Both are required to establish staff bylaws; therefore, both should be required to follow those bylaws. . . . Accordingly, we hold that Cohen may assert a cause of action in tort against St. Mary’s for failure to follow existing bylaws with regard to termination of his staff privileges.73

D. Permissible Standards

Once an aggrieved physician has established a constitutionally protected right deserving of judicial inquiry and protection, the courts require that the decision of the hospital be based upon constitutionally sufficient reasons or standards and that fair procedures including a “due process” hearing be given before such decision becomes final. We will first address that substantive criteria based upon which a Governing Body may grant, deny or revoke Medical Staff privileges and will then turn to the constitutionally required procedures.

1. The Fourteenth Amendment Standards

(a) Substantive Due Process

and a hospital which specifically required that “due process” be given upon cancellation of the contract. The contract did not provide for specific procedures of due process and the doctor argued that he had a right to the procedures contained in the hospital’s bylaws. The court sidestepped the issue, however, holding that even if he was right about being entitled to the bylaw procedures, the hospital had afforded him procedures that complied with the bylaws’ standards.

73St. Mary’s, 421 S.E.2d at 737.
A review of the cases in this area leads one quickly to the conclusion that the courts, once agreeing to review the merits of a Governing Body’s decision, are extremely reluctant to interfere with the decisions and discretion of the hospital’s Governing Body in setting the institution’s criteria for qualifications of staff membership and for imposing discipline. The seminal case applicable to hospitals in Georgia is the Fifth Circuit decision in Sosa v. Board of Managers of Val Verde Memorial Hospital, in which the court stated:

The governing board of a hospital must therefore be given great latitude in prescribing the necessary qualifications for potential applicants. . . . Human lives are at stake, and the governing board must be given discretion in its selection so that it can have confidence in the competence and moral commitment of its staff. The evaluation of professional proficiency of doctors is best left to the specialized expertise of their peers, subject only to limited judicial surveillance. The court is charged with the narrow responsibility of assuring that the qualifications imposed by the Board are reasonably related to the operation of the hospital and fairly administered. In short, so long as staff selections are administered with fairness, geared by a rationale compatible with hospital responsibility, and unencumbered with irrelevant considerations, a court should not interfere.

The Sosa decision has since often been quoted courts in the Fifth and Eleventh Circuits as a prelude to ruling for the hospital on substantive challenges to a variety of hospital actions. In short, as stated by the Eleventh Circuit in Silverstein v. Gwinnett Hospital Authority, the court’s inquiry for substantive due process purposes is the reasonableness of the standard and the absence of arbitrariness and capriciousness in its application.

(b) Equal Protection

In Silverstein, the court’s analysis of equal protection challenges to hospital eligibility standards for Medical Staff membership also reflects a traditional deference to the hospital Governing Body. Unless the criteria involve some fundamental right or suspect classification, the court will apply a rational basis standard. The hospital is free to adopt any standard reasonably related to the legitimate interests of the hospital. The court will

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74 437 F.2d 173 (5th Cir. 1971).
75 Id.; this case is recognized as binding precedent in the Eleventh Circuit, see, Bonner v. City of Pritchard, 661 F.2d 1206 (11th Cir. 1981) (en banc).
77 Silverstein, 861 F.2d at 1567.
78 Id. at 1564-65.
not determine the wisdom or utility of the classification; rather it will determine only whether any rational decision maker could have concluded that the classification would accomplish the stated end. Only a wholly arbitrary action can be set aside under this rational basis test.

2. **Antitrust**

Perhaps because hospitals are frequently successful in defending substantive due process and equal protection challenges, disappointed physicians have turned to antitrust law to challenge Governing Body and Medical Staff decisions limiting or excluding a physician from practice at a hospital. Such challenges are grounded upon the argument that excluding a physician from practice at a hospital has the effect of reducing competition among physicians. These challenges were initially facilitated by U.S. Supreme Court decisions which have adopted standards making it easier to prove a jurisdictional connection to interstate commerce in Medical Staff privilege cases, and which have acknowledged the applicability of traditional antitrust analysis to the health care industry. Although most of the cases have upheld hospital staff criteria and decisions on the rule of reason standard, there have been successful antitrust challenges.

3. **Specific Criteria**

(a) **Vagueness of Criteria**

Some physicians have sought to challenge Medical Staff bylaw criteria on grounds of vagueness. Recognizing the impossibility of detailed descriptions, the courts have approved general language such as “character, qualifications, and standing,” “unprofessional conduct,” or “inability to provide high quality medical care.” However one court refused to accept a bylaw provision requiring “the best possible care.” Because the courts have recognized that the goal of insuring a physician’s capabilities and judgment cannot be met unless wide latitude is given to the hospital to make judgments about the physician, they have been willing to accept general standards that repose substantial discretion and judgment in the Medical Staff and Governing Body.

(b) **Academic Credentials, Training, Board Certification**

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81See, e.g., Bellam v. Clayton County Hospital Authority, 758 F. Supp. 1488; Robbins v. Ong, 452 F. Supp. 110.
82See, e.g., Patrick v. Burget, 486 U.S. 94; Oltz v. St. Peter’s Community Hospital, 861 F.2d 1440.
83Sosa, 437 F.2d at 176.
84Moore v. Board of Trustees of Carson-Tahoe Hospital, 495 P.2d. 605 (Nev. 1972), cert. denied, 409 U.S. 879 (1972).
87Sosa, 437 F.2d 173.
In Smith v. Hospital Authority of Gwinnett County, the Georgia Supreme Court affirmed, without opinion, a superior court decision upholding a hospital’s requirement of allopathic post-graduate training as a condition of staff membership. The Superior Court stated that “[a] public hospital may deny staff privileges to a physician ... when said physician does not meet different and/or additional standards of training, experience, and competence as set by the bylaws of the medical staff” from those required for licensure by the State Board Medical Examiners. In Silverstein v. Gwinnett Hospital Authority, the Eleventh Circuit subsequently considered the same issue based upon a public hospital’s bylaw requirement that staff members must have completed training requirements for specialty board certification and a post-graduate training program approved by the Accreditation Council for Graduate Medical Education. Since the specialty boards and Accreditation Council are allopathic organizations, osteopaths challenged the bylaw as violative of equal protection, due process, and state law since osteopathic physicians who did not meet the criteria could not qualify for staff membership. The Eleventh Circuit rejected all challenges to these bylaw provisions, holding that the recognized distinctions between osteopathic and allopathic post-graduate specialty training provided a rational basis to require the allopathic training for the purpose of standardizing and assuring quality health care. The court also rejected state law claims against the bylaw requirement. Both of these decisions support the conclusion that the non-discrimination provisions of O.C.G.A. § 31-7-7 do not prevent the adoption of standards exceeding licensure requirements even though such standards impact more heavily on some schools of medicine or limited practitioners than on others.

(c) Required Licensure

It is typical for Medical Staff bylaws to contain provisions permitting the automatic suspension or revocation without right to a hearing or appeal of Medical Staff privileges of a physician whose medical license has been restricted, revoked or suspended by state licensure authorities. In one New York appellate decision, a suspension under such a provision was upheld against arguments that failure to provide a hearing violated state regulations requiring a mechanism for appeals in staff privileging decisions. The court held that such due process requirements applied only when the adverse action was a result of a decision made by the hospital not where it was the result of an act of the state licensure board.

(d) Failure to Comply With Bylaws Rules and Regulations

A corollary to the courts’ recurring recognition of the right of hospitals to adopt reasonable rules and regulations, as exhibited by the rationale of the Fifth Circuit in Sosa, is the willingness of the courts to

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89Silverstein, 861 F.2d 1560.
permit hospitals to deny or restrict privileges of physicians who refuse to abide by those rules and regulations. The Georgia courts have ruled in favor of hospital disciplinary actions where the physician refused to sign a form agreeing to abide by the rules and regulations of the hospital, and where the physician provided incomplete and false information on staff membership application forms and refused to comply with other instructions related to his application and temporary privileges. Another decision upheld discipline against a physician who refused to comply with hospital bylaws requiring emergency room coverage and service. The right of a hospital to adopt a policy requiring diagnostic and laboratory procedures and tests to be performed at the hospital facility has also been upheld. As long as the rule or regulation bears a reasonable relation to a legitimate interest of the institution so that it can withstand substantive due process and equal protection scrutiny, that is, they are not arbitrary or capricious, the hospital’s right to enforce them will be upheld.

(e) Ability To Work With Others

The courts have repeatedly been faced with challenges to hospital disciplinary decisions which were based upon findings of disruptive behavior or inability to work with others on the part of the physician. The courts have uniformly recognized that such behavior, when found to adversely affect quality of care or the efficient operation of the hospital, is a proper basis for discipline or revocation of privileges.

The tenor of the disputes and the analysis of the courts in such cases is illustrated by the following quotation from Judge Lawrence’s opinion in Robbins v. Ong:

At the hearing before this Court, patients of the Plaintiff and physicians attested to his ability as a doctor. His competence is not in issue. What is in issue is the turmoil and disruption he has brought to the Liberty County Hospital for years. Apparently he is imbued with the idea that where Dr. Robbins sits, there is the head of the table. Rules are for others, not him. The trouble with this conception is that the Hospital is a public institution, not his private domain. It is operated by the Authority, a thought which he apparently cannot tolerate.

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91 Yeargin v. Hamilton Memorial Hospital, 229 Ga. 870.
92 Dunbar v. Gwinnett Hospital Authority, 227 Ga. 534.
93 Yeargin v. Hamilton Memorial Hospital, 229 Ga. 870.
94 Cobb County-Kennestone Hospital Authority v. Prince, 242 Ga. 139.
95 Dunbar v. Gwinnett Hospital Authority, 227 Ga. 534; Bryan v. James E. Holmes Regional. Medical Center, Inc., 33 F.3d 1318 (11th Cir. 1994); Everhart v. Jefferson Parish Hospital District No.2, 757 F.2d 1567 (5th Cir. 1985); Huffaker v. Bailey, 540 P.2d. 1398; Robbins v. Ong, 452 F. Supp. 110; Seigel v. St. Vincent Charity Hospital and Health Center, 520 N.E.2d 249 (Oh. App. 1987); Bricker v. Seriea Speare Memorial Hospital, 281 A.2d 589; Magrinet v. Trinity Hospital, 540 N.W.2d 625 (N.D. 1995).
Personalities are at the heart of the problem. However, ‘it is entirely consistent with due process for a hospital ... to evaluate those personal qualities of a physician that reasonably relate to his ability to function effectively within a hospital environment. A doctor’s ability to work well with others, for instance, is a factor that could significantly influence the standard of care his patients received.’ [Citations omitted] It is for the Authority to decide whether personality differences are detrimental to the efficient operation of the hospital. This Court should not substitute its evaluation for that of the Authority.96

(f) Residence

The courts which have considered bylaw requirements of residency as a condition to staff membership are divided. Presumably, the rationale for such a requirement is to insure the availability of the physician within a reasonable time when needed to provide care to the physician’s admitted patients or to provide emergency service in the emergency room. The Fifth Circuit in Sosa referred to a residency requirement uncritically but that requirement was not in issue before the court. An Indiana court upheld a requirement that the physician live closely enough to provide continuous care,97 but the Fourth Circuit rejected a requirement that a physician live in the county.98

(g) Liability Insurance

Medical staff bylaw or hospital policy provisions requiring all physicians to secure and maintain professional liability insurance in at least minimum amounts as a condition of staff membership are quite common. Hospitals have justified such requirements as necessary to protect patients from insolvent physicians, to preserve hospital assets by lowering insurance costs, and to assure the hospital and other staff physicians that a negligent physician will be able to contribute to the cost of defense, settlements or judgments in the event a malpractice claim is asserted against multiple defendants. Persuaded by other courts which had approved such requirements,99 as well as prior Georgia case law emphasizing the hospital’s right to adopt reasonable rules and regulations as a condition to staff privileges, the Georgia Court of Appeals, in Stein v. Tri-City Hospital Authority, upheld a bylaw conditioning staff membership upon providing liability insurance and a decision by the hospital pursuant to such bylaw condition revoking the staff privileges of a physician.100

98Sams v. Ohio Valley General Hospital Assoc., 413 F.2d 826 (4th Cir. 1969).
(h) Closed Staff/Exclusive Contracts

Numerous cases have arisen from instances where hospitals have excluded physicians because of an institutional decision to limit the number of practitioners in the hospital or in certain specialties. It is not unusual to find contracts between hospital-based physicians, such as anesthesiologists, radiologists and pathologists, and hospitals granting particular physicians or groups of physicians exclusive rights to practice their specialty in the hospital. It is also not hard to find examples of hospitals who have simply determined not to accept any more staff members. Such decisions, of course, do not depend upon the qualifications of any specific applicant and give rise to antitrust as well as due process and equal protection concerns.

The use of exclusive contracts was upheld by the U.S. Supreme Court in Jefferson Parish Hospital District No. 2 v. Hyde, against antitrust challenges on the basis that such contracts were not illegal under the per se standard since the participant did not have a dominant market share but should be evaluated under the rule of reason standard. No showing was made that the exclusive contract had a proscribed anticompetitive effect in the New Orleans market area so no violation was found. However, in Oltz v. St. Peter’s Community Hospital, the Ninth Circuit found an exclusive contract for anesthesia services to constitute an agreement that unreasonably restrained trade based upon findings of an “agreement” between the hospital and the anesthesiologist which was intended to restrain trade as opposed to improve quality of care and which did have a substantial anticompetitive effect in the marketplace. The fact that the hospital in question before the Ninth Circuit was the only hospital in the area open to the public and capable of providing facilities for general surgery is in contrast to the existence of numerous hospitals in the New Orleans area providing the disputed services. Exclusive contract arrangements have been upheld by federal courts in Georgia on several occasions.

The closure of a hospital’s staff or the staff of a department in the hospital has been upheld by courts when the purposes were to promote efficiency and improved patient care and to limit the number of patients and procedures to the capacity of hospital facilities. However, criteria based on capacity may be struck down if exceptions to the closed staff policy are discriminatory and unrelated to any rational hospital purpose. For example, a closed staff policy allowing new physicians who join the practice of existing staff members to become members of the Medical Staff was rejected by one court. In a later decision, the same court struck down a

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101466 U.S. 2.
102861 F.2d 1440.
policy that allowed new physicians to join the staff if they had practiced less than two years.\textsuperscript{106}

The courts are also divided over whether hospital administrative actions to close a department or particular services require due process procedures for affected staff members. For example, the Eleventh Circuit, in \textit{Faucher v. Rodziewicz} \textsuperscript{107} held that a hospital’s administrative actions (leaving Medical Staff privileges unaffected) which had the effect of curtailing Dr. Faucher’s case load in favor of another physician group which had obtained a contract to provide anesthesia service did not implicate a property or liberty interest giving rise to protection under the Fourteenth Amendment. The Eleventh Circuit refused to consider the economic impact to Dr. Faucher of the administrative actions as rising to the level of a protected property interest. Similarly, the Eighth Circuit, in \textit{Englestad v. Virginia Municipal Hospital} \textsuperscript{108} refused to find that an administrative decision to remove the physician as director of the pathology department (which was argued to have made his staff privileges economically worthless) gave rise to due process procedural protections. The Kansas Supreme Court has held that no due process hearing was required by a hospital’s exclusion of physicians from a department as a result of an exclusive contract. The court concluded that since the business decision to enter into the contract and deny the plaintiffs access to the department were unrelated to the plaintiffs’ competency and conduct, thus no due process hearing was required.\textsuperscript{109}

On the other hand, where the loss of Medical Staff privileges occurred in connection with the termination of an exclusive contract which provided that it could only be terminated for cause, the Fifth Circuit, in a case arising out of Georgia, held that due process rights were required to be observed.\textsuperscript{110} The \textit{St. Mary’s} case, discussed above, also establishes that the termination of staff privileges by a hospital in conjunction with contract termination (even one terminable without cause) could be actionable if neither the bylaws nor a specific agreement with the physician waived rights to due process hearings upon termination of staff privileges in connection with the contract termination. An appellate court in Illinois held that an Illinois regulation requiring hospitals to include procedural due process rights in their bylaws required that the physician be provided a hearing when the decision was made to restrict open heart surgery to contract physicians.\textsuperscript{111} In Wisconsin, the Court of Appeals held that a hospital could not amend policies governing the ICU so as to deny affected physicians

\begin{footnotesize}
\textsuperscript{106}Berman v. Valley Hospital, 510 A.2d 673 (N.J. 1986).
\textsuperscript{107}891 F.2d 864; see also, Shaw v. Phelps County Regional Medical Center, 858 F. Supp. 954 (ED. Mo. 1994)
\textsuperscript{108}718 F.2d 262 (8th Cir. 1983).
\textsuperscript{109}Dutta v. St. Francis Regional Medical Center, 867 P.2d 1057 (Kan. 1994).
\textsuperscript{110}Northeast Georgia Radiological Associates, P.C. v. Tidwell, 670 F.2d 507 (5th Cir. 1982).
\textsuperscript{111}Garibaldi v. Applebaum, 653 N.E.2d 42 (Ill. App. 1995).
\end{footnotesize}
privileges without a due process hearing since the bylaws established a contract binding on the hospital.112

(i) Suspect Class Discrimination and First Amendment

Sex, race, creed or national origin are not permitted to be criteria for staff membership under the Joint Commission standards.113 The federal courts have uniformly found such criteria to violate federal civil rights statutes.114 It is established in the Eleventh Circuit that Title VII applies to hospital decisions on Medical Staff credentialing of physicians.115

Revocation of staff privileges by a public hospital can be a violation of the First Amendment if found to be in retaliation for the exercise of protected speech. However, the physician must prove that he or she engaged in protected speech and that such speech was a substantial or motivating factor in the adverse action. Then, unless the hospital can prove the adverse action would have been taken even in the absence of the protected speech, the revocation will be set aside. Applying the foregoing rules, the Eighth Circuit, in Smith v. Cleburne County Hospital, reversed the district court and upheld a hospital revocation of staff privileges. In so doing, the court held that where initial public comment on matters of public concern later degenerate into personal attacks on hospital officials and personnel which causes disruption, disharmony, dissension and adverse economic effects upon the hospital, the hospital’s decision did not violate the First Amendment.116

In Jimenez v. Wellstar Health System,117 the physician asserted that the suspension of his privileges following complaints about his care violated 42 U.S.C.A. §§ 1981 and 1985. The U. S. District Court for the Northern District of Georgia dismissed his claims under a Rule 12(b)(6) Motion to Dismiss. The Eleventh Circuit affirmed the dismissal, holding that he did not state a claim for racial discrimination under 42 U.S.C.A. § 1981 because he did not allege any interference with any right enumerated under the statute. Under Georgia law, he had neither a contract nor a property interest in maintaining his medical staff privileges at the hospital or, more broadly, in continuing to practice medicine.118

The Eleventh Circuit reached a significantly different result in Moore v. Grady Memorial Hospital Corporation.119 Dr. Moore had an

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113 Joint Commission, Manual, MS.06.01.03.
114 See e.g., Jatoi v. Hurst-Euless-Bedford Hospital Authority, 807 F.2d 1214 (5th Cir. 1987); Also see, Zaklama v. Mt. Sinai Medical Center, 842 F.2d 291 (11th Cir. 1988) and Doe v. St. Joseph’s Hospital of Fort Wayne, 788 F.2d 411 (7th Cir. 1986).
115 Zaklama v. Mt. Sinai Medical Center, 842 F.2d 291 (11th Cir. 1988); Pardazi v. Cullman Medical Center, 838 F.2d 1155 (11th Cir. 1988); contra, Diggs v. Harris Hospital-Methodist, 847 F.2d 270 (5th Cir. 1988).
116 Smith v. Cleburne County Hospital, 870 F.2d 1375 (8th Cir. 1989).
117 593 F.3d 1304 (2010).
118 Id. at 1311.
119 834 F.3d 1168 (2016).
employment contract with Morehouse School of Medicine, and to the extent that the suspension of his privileges by Grady were based upon a discriminatory act, he could not fulfill his contractual obligation to teach residents nor perform any clinical privileges. Thus, Dr. Moore’s 42 U.S.C.A. § 1981 discrimination claim, based upon the alleged impairment of his contract with Morehouse, should survive the hospital’s Motion to Dismiss.

E. Procedural Due Process – Peer Review

The above discussed constitutional and non-constitutional standards all build up to the question of how a Medical Staff is ultimately regulated. The most common method of regulation is through a process known as “peer review.” While the Federal Health Care Quality Improvement Act (“HCQIA”)\(^{120}\) has had a substantial impact on peer review throughout the country, the act does not actually contain a definition of “peer review.” Likewise, the Joint Commission Hospital Accreditation Standards uses the phrase “peer review” but neither describes nor defines what is meant of the term.\(^{121}\) Title 31 of the Official Code of Georgia Annotated contains at least three definitions and/or descriptions of “peer review.” The first definition relates to “peer review” in hospitals or ambulatory surgery centers and is contained in O.C.G.A. § 31-7-15:

(a)* A hospital or ambulatory surgical center shall provide for the review of professional practices in the hospital or ambulatory surgical center for the purpose of reducing morbidity and mortality and for the improvement of the care of patients in the hospital or ambulatory surgical center. This review shall include, but shall not be limited to, the following:

(1)* The quality of care provided to patients as rendered in the hospital or ambulatory surgical center;

(2)* The review of medical treatment and diagnostic and surgical procedures in order to foster safe and adequate treatment of patients in the hospital or ambulatory surgical center; and

(3)* The evaluation of medical and health care services or the qualifications and professional competence of persons performing or seeking to perform such services.\(^{122}\)

(b)* The functions required by subsection (a) of this Code section may be performed by a “peer review committee,” defined as a committee of physicians appointed by a state or local or specialty medical society or appointed by the governing board or medical staff of a licensed hospital or ambulatory surgical center or any other organization formed pursuant to state or federal law and engaged by the hospital

\(^{120}\) 42 U.S.C.A. § 11101 et seq.

\(^{121}\) Some of the elements of “Performance Improvement” contained within the Hospital Accreditation Standards would probably be considered to be peer review by most healthcare lawyers. See, e.g. the Elements of Performance under MS 3.10.

\(^{122}\) Note that for purposes of asserting privilege from discovery for “peer review” records, this broad definitional scope of “peer review” may be becoming more limited. See infra discussion of Hospital Authority of Valdosta and Lowndes County, v. Meeks, 285 Ga. 521 (2009).
or ambulatory surgical center for the purpose of performing such functions required by subsection (a) of this Code section.

(c)* Compliance with the above provisions of subsection (a) of this Code section shall constitute a requirement for granting or renewing the permit of a hospital or ambulatory surgical center. The functions required by this Code section shall be carried out under the regulations and supervision of the department.

(d)* Proceedings and records conducted or generated in an attempt to comply with the duties imposed by subsection (a) of this Code section shall not be subject to the provisions of either Chapter 14 or Article 4 of Chapter 18 of Title 50.

(e)* Nothing in this or any other Code section shall be deemed to require any hospital or ambulatory surgical center to grant medical staff membership or privileges to any licensed practitioner of the healing arts.

You will note that this definition of “peer review” actually contains four major elements: (i) the institutions’ care of the patient; (ii) the medical treatment provided by the physicians; (iii) the credentialing and re-credentialing of healthcare providers providing service in the institution; and (iv) the on-going evaluation of services within the institution.

The second definition of “peer review” is contained in O.C.G.A. § 31-7-131:

(1)* “Peer review” means the procedure by which professional healthcare providers evaluate the quality and efficiency of services ordered or performed by other professional health care providers, including practice analysis, inpatient hospital and extended care facility utilization review, medical audit, ambulatory care review, claims review, underwriting assistance, and the compliance of a hospital, nursing home, convalescent home, or other health care facility operated by a professional health care provider with the standards set by an association of health care providers and with applicable laws, rules and regulations.

(2)* “Professional health care provider” means an individual who is licensed, or an organization which is approved, to practice or operate in the health care field under the laws of Georgia, including but not limited to, the following individuals or organizations: (A) A physician; (B) A dentist; (C) A podiatrist; (D) A chiropractor; (E) An optometrist; (F) A psychologist; (G) A pharmacist; (H) A registered or practical nurse; (I) A physical therapist; (J) An administrator of a hospital, a nursing home or convalescent home, or other health care facility; (K) A corporation or other organization operating a hospital, a nursing or convalescent home, or other health care facility, as well as the officers, directors, or employees of such organization or organization of the members of such corporation’s or organization’s governing board who are performing a peer review function; (L) A rehabilitation supplier registered with the State Board of Worker’s Compensation; and (M) An occupational therapist.

(3)* “Review organization” means the Joint Commission of Accreditation of Health Care Organizations. Such term also means any other national accreditation body or any panel, committee, or organization:
(A) Which: (i) Is primarily composed of professional health care providers; (ii) Is an insurer, self-insurer, health maintenance organization, preferred provider organization, provider network, or other organization engaged in managed care; or (iii) Provides professional liability insurance for health care providers; and

(B) Which engages in or utilizes peer reviews and gathers and reviews information relating to the care and treatment of patients for the purposes of: (i) Evaluating and improving the quality and efficiency of health care rendered; (ii) Reducing morbidity or mortality; (iii) Evaluating claims against health care providers or engaging in underwriting decisions in connection with professional liability insurance coverage for health care providers; (iv) Compiling aggregate data concerning the procedures and outcomes of hospitals for the purposes of evaluating the quality and efficiency of health care services. Under no circumstances shall any such aggregate data or any other peer review information relating to an individual professional health care provider be disclosed or released to any person or entity without the express prior written consent of such health care provider, but such aggregate data or other peer review information may be released to another review organization upon the written request of such organization if such requesting review organization has specific reason to believe that immediate access to such aggregate data or information is necessary to protect the public health, safety, and welfare. Such aggregate data and other peer review information shall be used for peer review purposes only and in no event shall such aggregate data or any other peer review information be sold or otherwise similarly distributed, but a review organization shall be authorized to utilize the services of any pay a fee to another person or entity to compile or analyze such aggregate data; (v) Evaluating the quality and efficiency of health care services rendered by a professional health care provider in connection with such provider’s participation as or request to participate as a provider in or for an insurer, self-insurer, health maintenance organization, preferred provider organization, provider network, or other organization engaged in managed care; or (vi) Performing any of the functions or activities described in Code Section 31-7-15.

Note that “peer review” in this statute not only includes licensed health care professionals, but also includes the administrators of health care facilities, claims review personnel, underwriting assistants, compliance activities and the officers, directors and employees of any entity in the performance of peer review function.

Finally, “peer review” is described, if not defined, in O.C.G.A. § 31-7-140, which provides:

As used in this article, the term “medical review committee” means a committee of a state or local professional society or of a medical staff or a licensed hospital, nursing home, medical foundation, or peer review committee, provided the medical
staff operates pursuant to written bylaws that have been approved by the governing board of the hospital or nursing home, which committee is formed to evaluate and improve the quality of health care rendered by providers of health service or to determine that health services rendered were professionally indicated or were performed in compliance with the applicable standard of care or that the cost of health care rendered was considered reasonable by the providers of professional health services in the area.

“Peer review,” as described in this section, specifically includes a review of all of the following issues: (i) The evaluation of the quality of health care; (ii) The determination that the health services were indicated; (iii) That health services were performed in compliance with the applicable standard of care; or That the cost of health services was reasonable.

These statutory definitions of “peer review” have been amplified in a number of appellate decisions in Georgia, including Georgia Hospital Association v. Ledbetter, in which the Court differentiated between peer review activities and reports generated as part of the State hospital licensure activities. In Eubanks v. Ferrier, the Supreme Court described peer review as a method for in-house review of clinical work performed in a hospital. Scott v. McDonald describes proceedings involving the review and investigation of an individual physician’s standard of care and the treatment of his patients as well as the examination of the propriety of procedures utilized within the institution in order to take curative action to remedy questionable procedures. Additionally, the Georgia Court of Appeals in the third appellate appearance of Patton v. St. Francis Hospital described a complex peer review process and found that the immunity provisions of the federal and state statutes applied.

1. What is “routine” peer review?

The first, and perhaps the most critical, type of routine peer review is the credentialing of physicians at the point at which they are admitted to the Medical Staff and provided “privileges” to perform procedures within the institution. The obligation of an institution to ensure that a physician is qualified to provide the care offered and the resultant liability for a failure to do so was first recognized in the seminal case of Darling v. Charleston Community Memorial Hospital. Numerous commentators have opined that credentialing is the most important activity in the peer review process. Appropriate due diligence in the credentialing process is mandated by the Joint Commission’s comprehensive Hospital Accreditation standards, as well as Medicare’s Conditions of Participation for hospitals. As discussed in Section II, above, Georgia institutions which are
accredited by a nationally recognized accreditation body, including the Joint Commission are entitled to “deemed” licensure status.130

Confusion within the Georgia courts regarding the credentialing process had existed until the amending of O.C.G.A. § 31-7-131. The amendment added section (3)(B)(vi) which refers to a peer review organization as any organization “… performing those functions or activities described in Code Section 31-7-15.” O.C.G.A. § 31-7-15 specifically includes the evaluation of “…the qualifications and professional competence of persons performing or seeking to perform [physician] services.”131

Pursuant to the Joint Commission guidelines, it is also necessary that the re-credentialing of healthcare professionals be performed on a regular basis, typically every two years.132 Ultimately the law provides that the Governing Body of the hospital is responsible for the quality of medical care provided to patients.133

In addition to credentialing, routine peer review includes a regular analysis of medical charts and activities in order to measure, assess and improve actions within an institution regarding a number of matters including, but not limited to: (i) the medical assessment and treatment of patients; the use of medications; (ii) the use of blood and blood components; (iii) the use of operative and other procedures; (iv) the efficiency of clinical practice patterns; and (iv) any significant departures for established patterns of clinical practice.

From a practical standpoint, periodic pronouncements by the Joint Commission regarding areas of emphasis from year to year often guide healthcare institutions as to areas of concentration for peer review, in addition to other routine indicators. Routine indicators often include, but are not limited to, unexpected deaths, unexpected returns to surgery, nosocomial infections, medication errors, patient falls, equipment malfunctions, and failure of correlation between surgical specimens and x-rays with clinical findings.

Routine peer review is generally performed at the “section” or “department” level in a health care institution. For instance, the department of surgery may conduct routine peer review itself or may have a surgery quality assurance committee that reviews various charts which have been identified as “falling out,” based upon previously designated criteria, which will cause a chart to be brought to the attention of the committee (such as an unexpected return to surgery). Typically these charts will be reviewed at the committee level by a reviewer who, to the extent possible, will not know the identity of the physician he or she is reviewing, to determine whether or not the “indicator” which caused the chart to “fall out” can be explained.

If there are significant questions or concerns about the chart, the physician or healthcare professional providing the care is often asked to appear before the

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130 O.C.G.A. § 31-7-3(b).
131 O.C.G.A. § 31-7-15.
132 Joint Commission, Manual, MS 7.01.01.
133 42 C.F.R. § 482.21.
committee to address the committee’s concerns. The committee, with the assistance of institutional personnel, will classify and then typically “trend” the physician’s activities to ascertain whether any concerns regarding the care provided was an aberration or whether a pattern is noted which might require corrective action. Such corrective action may entail counseling with the physician, additional study of a procedure or technique, further monitoring, proctoring, and/or additional education. If the matter rises to a sufficient level, or extends over a period of time, and is not corrected by less intrusive action, a suspension or limitation of a physician’s privileges to perform that particular procedure may be recommended.

When corrective action or clinical behavior requires the imposition of proposed remedies that include suspension or revocation of a practitioner’s privileges, then the physician is typically provided certain due process as defined under the HCQIA and, typically, the Medical Staff bylaws and policies and procedures of the institution.

There are two other areas which may generate corrective action that may give rise to procedural rights and “fair hearings” under the hospital bylaws and/or policies and procedures and the HCQIA. One involves practitioners who suffer from physical and mental impairment where corrective action might be taken. The other occurs when the physician is involved in what is generally referred to as “disruptive behavior.”

2. The Scope of “Peer Review” and its Effect on Confidentiality.

The scope of what is considered “peer review” is now, more than ever, vital to the parties involved, as that question now determines whether records from peer review proceedings are immune from discovery in subsequent tort actions (including actions for negligent credentialing). While historically peer review proceedings were broadly treated as confidential and immune from discovery in later litigation, the tide has turned toward more disclosure and less confidentiality.

In the case of Hospital Authority of Valdosta and Lowndes County v. Meeks, the Supreme Court of Georgia significantly reduced the protections granted to peer review records. The case involved a patient’s estate which brought an action for negligent credentialing against the hospital wherein the surgery was performed. During discovery, the hospital was granted a protective order from turning over the records stemming from the peer review process of credentialing the physician in question. The trial court’s decision to grant the motion was based on the understanding that records created in furtherance of peer review proceedings were protected from discovery under Georgia law to allow for full candor between the parties involved in the proceedings.

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136 Id.
137 Id.
138 Id. at 521-522.
On *cert.*, the Supreme Court of Georgia held the protective order to be improper and sided with the patient’s estate. The Court reasoned that a careful reading of O.C.G.A. § 31-7-131 reveals that the statute addresses the “evaluation of the quality and efficiency of actual medical care services and does not encompass the credentialing process to the extent that every decision to extend or maintain staff privileges is a peer review or medical review function.” The Court held that information in a physician’s credentialing file was discoverable to the extent that it did not involve a peer review or the medical review committee’s evaluation of actual medical services provided by the physician.

The Court’s “careful reading,” however, did not consider the specific provision within O.C.G.A. § 31-7-51(a)(3) which defines a review of professional practices by a peer review committee to include “[t]he evaluation of ... the qualifications and professional competence of persons ... seeking to perform [medical and health care] services.”

The Court’s current reading of O.C.G.A. § 31-7-131 limits the records that can be considered peer review, and, consequently, which records relating to “peer-review-like” activities may be considered “not confidential” and therefore discoverable in subsequent litigation. Accordingly, information regarding a physician’s background, as required by the Georgia Uniform Healthcare Practitioner Credentialing Application Form, and primary source verifications (and potential candid recommendations) are now all potentially fair game for subsequent discovery.

The importance of this shift in the law should not be underestimated. The sense of protection from outside influences necessarily colors the level of candor among the professionals involved in the peer review process. Prior to *Meeks*, a high level of openness and frank narrative during peer reviews had been encouraged, in the hope of increasing the safety and patient care quality of each institution through such uninhibited discussions. The decision in *Meeks* necessarily affects the sense of protection for participating professionals, and may have caused some loss of comfort by members of healthcare credentialing committees. Whether patient care has suffered as a result of the Court’s decision to lower the protections given to peer review records remains to be seen.

### 3. The Health Care Quality Improvement Act (HCQIA)

The Federal Health Care Quality Improvement Act of 1986 (“HCQIA”) provides both carrot and stick to healthcare institutions in performing peer review actions within their Medical Staff. It grants such entities immunity from money damages as a result of adverse professional review actions that relate to the competence or professional conduct of an affected physician. Note that the

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139 Id.
140 Id. at 523.
141 Id. at 522.
142 O.C.G.A. § 31-7-15(a)(3).
144 42 U.S.C.A. § 11151.
HCQIA only offers immunity from money damages and not necessarily from injunctive or equitable relief. It does not prevent a suit from being instituted. Consequently, peer review activity should be structured, to the extent possible, to conform to both the Federal and Georgia statutes.\textsuperscript{145}

4. \textbf{Requirements for Immunity under HCQIA}

The protection afforded under the HCQIA is based on the concept of providing basic fairness to physicians who are the subject of peer review process. Provided that a proceeding is conducted in compliance with the provisions of the HCQIA, then participants have immunity in the event of litigation. On the other hand, institutions which do not comply with the provisions of the HCQIA lose their immunity from suit. Specifically, the institution loses its immunity if it fails to report to the National Practitioner Databank the names of physicians who are subject to specified corrective action within the institution. This duty to report cannot be eliminated or contracted away by the hospital’s bylaws or private physician agreement.\textsuperscript{146}

To obtain the protection afforded by the HCQIA, four specific standards must be met in the institution’s peer review activity. Specifically, the actions must be taken: (i) in the reasonable belief that the action was in the furtherance of quality healthcare; (ii) after a reasonable effort to obtain the facts in the matter; (iii) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances; and (iv) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain the facts and after meeting the requirements set forth above.

A professional review action is presumed to meet the four standards unless the presumption is rebutted by a preponderance of the evidence.\textsuperscript{147} Basically, this requires the physician challenging a peer review action to prove by a preponderance of the evidence that one of the four requirements has not been satisfied.\textsuperscript{148}

Importantly, in determining whether the four requirements of the HCQIA have been met, the courts have adopted an objective standard. Therefore, it does not matter what the respective parties felt regarding the matter; the real issue is whether there was a reasonable basis for the institution’s actions, as judged from the available evidence.\textsuperscript{149}

Generally, the HCQIA does not preempt state laws to the extent that the state laws provide greater protection than that contained within the federal


\textsuperscript{147} 42 U.S.C.A. § 11112.

\textsuperscript{148} As a practical matter, it is important that the burden of proof be specified within the Medical Staff bylaws of an institution conducting corrective action as part of its peer review process. In the absence of a specific statement of the burden of proof, the institution should rely upon the standard as set forth in the HCQIA.

\textsuperscript{149} Northeast Georgia Medical Center v. Davenport, 272 Ga. 173 (2000).
However, in *Patton v. St. Francis Hospitals*, the Court of Appeals of Georgia held that to the extent the peer review and medical immunity provision under Georgia’s peer review statutes were conditioned upon absence of malice and deception, those statutes would be preempted by the HCQIA. Typically though, courts have tried to show a great deal of deference to the medical judgment of a hospital or healthcare institution in determining whether to grant or deny privileges. The Court of Appeals of Georgia has consistently reiterated that “the court’s role is not to substitute its judgment for that of the hospital’s Governing Body or to re-weigh the evidence regarding the renewal or termination of Medical Staff privileges.”

The practical effect of the National Practitioner Databank under the HCQIA has been to place greater emphasis on Medical Staff corrective action because of the potential impact a negative report to the Databank could have on a physician’s future practice. Consequently, many physicians who often would have responded to peer review actions in the past by leaving an area and setting up practice elsewhere now will retain counsel and engage in very contested hearings, since leaving under such circumstances would be a reportable event to the Databank. If the hearing does not satisfy the practitioner, he or she will often attempt to find mechanisms to seek legal relief in the event of an adverse action.

From a practical standpoint, unfortunately, not many attorneys are familiar with Medical Staff hearings. Many physicians who are the subject of peer review actions often will utilize their business attorneys, or aggressive litigators (often criminal attorneys), to represent them in the proceedings. Such attorneys often seek to engage in discovery, which is typically not provided under Medical Staff bylaws and is not required under either federal or state law (except to the limited extent that the procedure under the HCQIA should be “fair to the physician under the circumstances”). Such attorneys often seek to engage in a number of procedural actions, requiring an experienced and diligent hearing officer to attempt to address the issues under the provisions of the Medical Staff bylaws and the applicable law.

The physicians who typically serve as the “jury of peers” in a Medical Staff hearing are typically attempting to examine the merits of the corrective action from a medical standpoint utilizing their scientific approach. The Medical Staff hearing committee members are often extremely frustrated with the procedural, evidentiary

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150 42 U.S.C.A. §11115.
152 There may be a split in authority on this preemption issue. While the Georgia Court of Appeals in the *Patton* case of 2003 clearly stated Georgia statutes which condition immunity upon the absence of malice and deception are preempted by HCQIA (under which bias is irrelevant), the court later implied in the 2008 case *Burrowes v. Northside Hospital* that the Georgia statute was not preempted by HCQIA and that a peer reviewer’s state of mind or malicious motive is material. See 294 Ga. App. 472 (2008). See also *Taylor v. Kennestone Hospital, Inc.*, 266 Ga. App. 14, 21-22 (2004) (The HCQIA only preempts the O.C.G.A peer review statutes to the extent they conflict. Because the HCQIA does not provide immunity against claims for equitable relief, statutes granting such immunity do not conflict).
153 *University Health Services, Inc. v. Long*, 274 Ga. 829 (2002); see also *Burrowes v. Northside Hospital*, 294 Ga. App. 472 (a challenge to a peer review proceeding must overcome a strong presumption of reasonableness).
and adversarial actions of counsel. In such an event, aggressive litigation counsel can often be counterproductive to the interest of their clients.

5. Initiation of an Investigation

Under the typical Medical Staff bylaws, a peer review investigation may typically be initiated by the leadership of the section or department in which the physician practices. Such a review typically is initiated as a result of the activities of the quality assurance or peer review committee of the specific section; often when a “trend” of questionable clinical behavior has been noted. In certain instances, a single catastrophic event in the care of a patient might result in corrective action being initiated.

Additionally, peer review investigations may be initiated in the credentialing and re-credentialing of a physician. This often occurs as a result of the activities of the credentialing committee, but is based upon trends that are typically identified through the quality assurance committees of the physician’s applicable section or department. From a practical standpoint, the risk management or quality assurance of the Medical Staff services office provides administrative services for such committees and often do the day to day work on issues which are brought to the committee’s attention for its evaluation, assessment and recommendation.

Certain types of behavior may result in corrective action being instituted by the Medical Staff leadership. These matters are usually brought to the attention of the MEC, which is essentially the board of directors of the Medical Staff. The MEC is typically composed of the generally elected Medical Staff officers; often identified as the chief of staff, the chief of staff elect (or vice chief), the secretary of the Medical Staff and, typically, the chiefs of each of the clinical services (and sometimes their vice chiefs). Clinical services will often include departments of surgery, medicine, OB/GYN, pediatrics, radiology, pathology, anesthesiology, emergency medicine and often numerous sub-specialists such as cardiology, orthopedics, and gastroenterology. The kinds of actions that typically are brought up in such a setting could include disruptive behavior such as physicians fighting with other physicians, significant patient complaints, or criminal or other behavior in the community that causes significant disruption in the institution.

Often, corrective action might be referred to the Medical Staff by members of the hospital’s “administration.” “Administration” within a hospital is defined to include not only the actual administrators, but the staff clinical personnel, such as the nursing staff, physical therapists, respiratory therapists, and x-ray and lab technicians. Matters that might be referred to administration for corrective action could involve sexual harassment claims against the hospital staff, altering medical records, or appearing at the facility while intoxicated.

Unless the action is the result of a catastrophic event, typically the issue will be referred to either the “section” or the MEC leadership for an investigation to be conducted to ascertain whether there is reasonable cause for corrective action. Often the issue will be investigated by a committee of the Medical Staff, a section
of the Medical Staff, or by the MEC itself. While not typically required under most Medical Staff bylaws, the better practice is that a concerted effort be taken to obtain the response of the affected practitioner to the allegations or concerns expressed regarding his action or behavior. Once again, the attempt is to take actions that can later be deemed from an objective standpoint to have been “reasonable under the circumstances.”

In the course of conducting an investigation regarding clinical competence, particularly within the section or department in which a physician practices, it is inevitable that the views of individuals who may be deemed to be competitors of the affected physician might be solicited. From a practical standpoint, it is important that if it appears that serious corrective action may be required, the investigation should be structured in such a way as to minimize the direct impact of any competitors. Likewise, it is important in the investigative process that everyone participating takes extreme care to maintain confidentiality so as to comply with both the Federal and State immunity and confidentiality peer review protections.

Finally, physicians subject to potential peer review should take special notice of the recently decided Doe, M.D. v. Leavitt. In Doe, the United States First Circuit Court of Appeals interpreted the word “investigation” in the HCQIA to pertain to all actions commencing from the peer review notice through either an issuance of a final action or a formal close to the proceedings. This decision is crucial as it unequivocally rejects the notion that “peer review proceedings” can be a set of discrete occurrences. Thus, counsel for an affected physician should make clear that if the physician resigns at any point after the issuance of an investigation notice, but before a final action or formal close to the investigation, that physician can be reported to the National Physician Data Bank for resigning “while under an investigation.”

6. Recommendation for Corrective Action

Typically, after an investigation, a recommendation regarding corrective action is made and forwarded to the MEC. The MEC should exercise due diligence in its consideration of the recommendation. Often, due diligence includes an interview with the affected practitioner and allowing the affected practitioner the opportunity to once again state his or her position regarding the matter. Such due diligence is particularly important if the MEC ultimately recommends corrective action that would result in either (i) the denial or termination of Medical Staff privileges, (ii) the suspension of a physician for more than 30-days, or (iii) significant limitations on the privileges of the physician. In the event of such a recommendation, the practitioner is typically entitled to what many bylaws call a

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155 552 F.3d 75 (2009).
156 Id.
157 42 C.F.R. § 60.1.
“fair hearing.” It is particularly important that the provisions of the HCQIA be addressed in the hearing.158

7. Notice of the Recommendation

One of the requirements of fundamental procedural fairness outlined in the HCQIA is adequate notice and an opportunity to be heard before an impartial party. The notice requirement means that the physician must be informed of the specific recommendations made and the basis for such recommendation. The notice must also comply with any other provisions contained in either the bylaws or any applicable state act and must be specific enough to adequately put the affected practitioner on reasonable notice.159

In order to meet the HCQIA requirements for adequate notice, the notice must contain the following elements: (i) that a professional review action has been proposed to be taken against the physician; (ii) the reasons for the proposed actions; (iii) the physician’s right to request a hearing on the proposed action; (iv) the time limit (no less than 30-days) within which the physician must request such a hearing; and (v) a summary of the physician’s hearing rights.160

The specificity of the notice must be carefully considered. In Northeast Georgia Medical Center v. Davenport, the Court of Appeals of Georgia held that notice provided by an institution can actually be too specific.161 In Davenport, the affected practitioner received two notification letters with a laundry list of events, patient records and witnesses. Ultimately, in reversing the Court of Appeals, the Supreme Court of Georgia held that adequate notice under the HCQIA does not mandate a formal or precise manner and scope.162 The Court opined that “[n]o court has adopted the anomalous requirement that a hospital which provides an overabundance of notice does not comply with the HCQIA.”163

If the physician requests a hearing on a timely basis, then the physician must be given a notice that provides: (i) the date, time and place of the hearing (not less than 30-days after the date of the notice); (ii) a list of the witnesses expected to testify at the hearing on behalf of the institution; and (iii) a statement regarding the physician’s right to be represented by counsel.

8. Hearing Rights and Procedures

If a hearing is requested, the hearing must be held before one of the following: (i) an arbitrator mutually acceptable to the physician and the hospital;

158 Note: Written reprimands, warnings or routine determinations that the physician must be supervised or proctored while performing certain procedures typically do not trigger a hearing. In those cases, a physician’s clinical privileges and Medical Staff appointment remain intact. Consequently, the due process requirements of the HCQIA will not necessarily arise.
159 42 U.S.C.A. § 11112.
160 Id.
163 Id. at 176.
(ii) a hearing officer who is appointed by the hospital and is not in direct economic competition with the physician involved; or (iii) a panel of individuals who are appointed by the hospital and are not in direct economic competition with the physician involved. While the hospital may choose which of the three methods may be used, typically most Medical Staff bylaws provide for a panel of physicians so that determinations regarding peer review are indeed conducted by "peer physicians."

The HCQIA codified provisions that had generally been accepted (and often mandated) by state laws. The provisions grant a physician the rights to: (i) representation by an attorney or other person of the physician’s choice; (ii) have a record made of the proceedings, copies of which may be obtained by the physician upon payment of any reasonable charges associated with the preparation thereof; (iii) call, examine, and cross-examine witnesses; (iv) present evidence determined to be relevant by the hearing officer, regardless of its admissibility in a court of law; (v) submit a written statement at the close of the hearing; (vi) receive the written recommendation of the arbitrator, officer or panel, including a statement of the basis for the recommendations; and (vii) receive a written decision of the health care entity, including a statement of the basis for the decision.164

Consequently, the Medical Staff bylaws typically provide for the appointment of a hearing officer who is often an experienced healthcare attorney who assists in matters of procedure and evidence and may serve as counsel to the hearing panel, but does not actually vote in its deliberations.165 However, the appointment of the hearing officer is not always without challenge by the affected practitioner. In 2004, the California Court of Appeals for the Sixth District overturned a decision of a hospital’s fair hearing committee, finding that the hearing officer (a retired appellate judge) had a potential conflict of interest because he had previously served on the hospital’s foundation board, was paid by the facility, and had a potential financial conflict because he might be selected as a hearing officer in future hearings.166 Although the case has been discussed a great deal by healthcare lawyers, it has generally been considered an anomaly based upon California statutory law, and a lack of understanding by the court that the institution generally has as strong an interest in assuring the integrity of the fair hearing process as the affected practitioner.

If a hearing panel has been chosen at the time of the written notice, the health care facility is generally advised to include the names of the panel members

164 The 11th Circuit has reinforced the position that hospitals need only “substantial compliance” with hospital bylaws when making staff privilege decisions, and that Medical Staff decisions will generally be upheld unless “arbitrary and capricious. Lee v. Hospital Authority of Colquitt Co., 397 F.3d 1327 (11th Cir. 2005).
165 Typical Medical Staff bylaw provisions for the hearing officer include the following: “The Executive Committee may request that the Board appoint a hearing officer to preside at any hearing. If a hearing officer is so appointed, the hearing officer, if feasible, shall not be in direct economic competition with the Practitioner involved. The hearing officer shall be experienced in conducting hearings, shall act in an impartial manner, and shall have the same general type of authority in the conduct of the hearing as would an administrative law judge acting in a similar administrative hearing. The hearing officer may participate in any deliberations of the Fair Hearing Committee but shall not be entitled to vote on the matter.” (Excerpt: Northside Hospital, Medical Staff Bylaws).
in the notice letter as well, so that the affected practitioner may object to any panel members well in advance of the hearing. While there are no specific requirements for voir dire in either the HCQIA or the Georgia statutes, the requirement that the panel member not demonstrate any malice, not be in direct economic competition with the affected practitioner, and, under many Medical Staff bylaws, not have previously participated in the consideration of the matter, does necessarily require some limited voir dire.

9. **Witnesses**

The issue of witnesses is difficult in hotly contested Medical Staff hearings. Oftentimes, the witnesses include nurses, mid-level providers, and hospital support personnel who are unsure of their rights or obligations to discuss peer review matters with respective counsel. Such individuals are often concerned about intimidation by counsel and possible retaliation by either the affected practitioner or the institution. In many instances, the hospital staff employees may genuinely like the affected practitioner yet be concerned about his or her quality of care.

In all instances witnesses, should be informed that they will not be compelled to speak to any party in advance of the hearing. In fact, under most Medical Staff bylaws, there is no provision to compel the attendance of any witness at the proceeding. In other instances, the staff personnel recognize that they may be called upon to work with the affected practitioner long after the peer review proceedings have concluded and are concerned about the lingering effect of having served as a witness for or against the practitioner. To deal with such issues, creative procedures are sometimes utilized including working with the chief nursing officer, institutional risk manager or other individual who might help set up and be present and supportive for hospital personnel in a joint session in which counsel for both the MEC and the affected practitioner might interview the individual. Such procedures are not the norm, however, and should be utilized with care.

In many instances the affected practitioner will attempt to defend his or her actions by asserting that he or she was doing basically the same thing as other physicians. In other instances, the affected practitioner may assert that he or she is being discriminated against and that other physicians have taken similar actions but not received similar types of discipline. While the physician has the right to call, examine and cross-examine witnesses, except in extremely rare and narrow instances it is not appropriate to permit the affected practitioner to inquire into peer review actions taken as to other practitioners or in regard to other proceedings.

10. **Composition of the Hearing Panel**

The members of the hearing panel must not be in “direct economic competition” with the affected practitioner. In many institutions, however, there is the suggestion or requirement that at least one member of the panel practice in the

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168 In Smith v. Ricks, 31 F.3d 1478 (9th Cir. 1994), the Ninth Circuit Court of Appeals provided that “nothing in the [HCQIA], legislative history, or case law suggests that the competency of other doctors is relevant in evaluating whether [the institution] conducted a reasonable investigation into [the doctor’s] conduct.”
same specialty as the physician requesting the hearing. In some instances that may obligate the institution to go outside of its own Medical Staff to identify such an individual. If the Medical Staff bylaws do not specifically provide for such a step, the hearing officer will often attempt to get counsel to stipulate to such an approach. Alternatively, in some instances the MEC will utilize an individual in the same specialty to serve as its “expert witness” to deal with the specific clinical matters at issue. Counsel for the MEC must weigh the credibility of such an individual with care, since the individual might be deemed by the practitioner’s counsel as someone in direct economic competition with the affected practitioner.

Ironically, the HCQIA does not specifically require that the hearing be held before “peers” of the physician. In some instances, nurses, former board members and even community representatives might be used as panel members. In such an event, it is important that the hearing officer properly instruct such individuals regarding the limitations and protective provisions of law regarding peer review matters. Generally, most institutions limit hearing panels to other physicians, thus helping ensure the credibility of the proceeding and its perception as a true “peer review” proceeding.

Some institutions are concerned about inappropriate contact or influence on panel members if their identity is divulged in advance of the hearing. If the issue is not addressed in the Medical Staff bylaws, an experienced hearing officer will provide appropriate warning in regard to such matters, often he or she will instruct the hearing committee members that any inappropriate contact should be reported to the hearing officer.

11. **Hearing Procedure**

While there is no specific requirement as to the methodology of the Medical Staff hearing, Medical Staff bylaws often contain some guidance. In the absence of such guidance, experienced healthcare attorneys have developed some generally accepted courses of conduct as described herein.

Under most Medical Staff bylaws, the ultimate burden of proof is on the affected practitioner to establish, by a preponderance of the evidence, that the institution failed to comply with one or more of the four requirements of the HCQIA. More specifically, it is often expressly provided in the Medical Staff bylaws that the practitioner must establish by a preponderance of the evidence that the corrective action recommended is not warranted or that the action taken was either arbitrary, capricious, or not supported by credible evidence.

Often, the Medical Staff bylaws will specifically provide that the MEC has the initial burden of presenting a “prima facie” case that corrective action was warranted, and the specific facts supporting the basis for its recommendation. In some rare instances, the Medical Staff bylaws may in fact provide that the MEC has the ultimate responsibility of establishing that its recommendation is reasonable under all the facts and circumstances.
Absent specific direction to the contrary, typically counsel for the MEC will initially present its case with counsel for the practitioner having full right of cross-examination. Importantly, while the HCQIA specifically identifies representation by an attorney as an element of “adequate” procedures, the specific role of such an attorney is not defined. Some hospitals, and ultimately some hearing panels, may seek to limit the role of attorneys. Physicians often feel that lawyers in the proceedings protract and attenuate what they consider to be basically a scientific and collegial procedure. The hearing officer has to attempt to moderate such limitations (by seeking in most instances to develop a consensus among counsel) so as not to leave the institution subject to an attack that the right to counsel under HCQIA was frustrated by the procedures utilized.

Unlike trial juries, panel members in Medical Staff hearings are entitled to (and often are encouraged to) ask questions and be full participants in the procedure. In many instances the panel may ask for additional documentation and may request that either party bring additional witnesses for the panel to examine. Often the panel will express its frustration about the proceedings to the hearing officer or a hospital administrative representative. In many instances the panel will ask for conferences with the hearing officer outside the presence of counsel to inquire as to its role and seek ways in which to expedite the proceeding and minimize what it considers to be a waste of time by the attorneys in getting to the “real issues.”

12. Admissibility of Evidence

Typically the Medical Staff bylaws will expressly provide that a Medical Staff hearing is not a trial and that technical rules of evidence should not apply. Bylaws will often expressly provide that the hearing panel is entitled to rely upon such documents and testimony (including hearsay) as might otherwise be utilized in individuals in matters of appropriate import.

13. Deliberations and Recommendation

Within a reasonable time after the hearing, the hearing panel should convene to deliberate and reach its decision. Medical staff bylaws and the HCQIA typically provide that at the close of the proceedings the affected practitioner has the right to present a written statement in regard to his position. However, such statements are often waived depending upon whether the proceedings have lasted over an extended period of time. To comply with the HCQIA requirements, the hearing panel should deliberate and prepare a written report and recommendation to advise the physician of its decision and the underlying rational supporting the action recommended. It is at this important point in the proceeding that an experienced hearing officer can be most effective in making sure that the hearing panel, in its deliberations, appropriately addresses all of the issues that are raised in the notice, documents the appropriate “due diligence” utilized in the hearing

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169 Quite frankly, if the proceedings have extended over an extended length of time, written closing arguments are often preferable to oral closing arguments because they can include citations to the record.
process, and clearly delineates a recommendation that is consistent with the HCQIA and the bylaws.

14. • **Appeal**

Neither the HCQIA nor the Georgia statutes deal with the right to appeal a recommendation made through a “fair hearing” committee. Typically, however, Medical Staff bylaws do provide a right to appeal an adverse recommendation to the Governing Body, who, under Georgia law, has ultimate responsibility for the quality of care provided to the institution. Such an appeal, however, should not be a second hearing. It is typically an appellate review based upon evidence and materials contained within the record to determine whether the hearing was fairly conducted and whether the recommendation was supported by the evidence.
12:00 LUNCH AND PRESENTATION
LEGENDS OF GEORGIA HEALTHCARE LAW
SERIES: HEALTHCARE LAW EDUCATION
IN GEORGIA
Charity Scott, Georgia State University, School of Law, Atlanta
Are you stressed out? Overwhelmed with work? Feeling disconnected from clients or colleagues, or from family and friends? Sensing a loss of meaning in your practice? You are not alone: recent studies confirm a crisis in well-being among lawyers. This article discusses how mindfulness can help you to cope with the inevitable challenges of being a good lawyer and to find renewed health and happiness in your life.

Crisis in Professional Well-Being

“To be a good lawyer, one has to be a healthy lawyer. Sadly, our profession is falling short when it comes to well-being, . . . [R]esearch suggests that the current state of lawyers’ health cannot support a profession dedicated to client service and dependent on the public trust.”1 So begins the recent report by the National Task Force on Lawyer Well-Being (the “Task Force”). The Task Force represents professional organizations both inside and outside of the American Bar Association.

Research shows high rates of mental and behavioral health problems among lawyers. For example, a 2016 study of over 12,000 lawyers reported incidence rates for the several conditions as follows: for depression, 28 percent; for stress, 23 percent; for anxiety, 19 percent; and for problematic drinking, 21 percent (up to 36 percent depending on the screening test used).2 Attorneys who screened positive for problematic drinking were at significantly higher risk for depression, anxiety, and stress.3 In a profession that embraces an “alcohol-based social culture,”4 alcohol is the number-one substance abuse problem for attorneys, with abuse of prescription drugs in second place.5 One substance-abuse recovery expert who works with lawyers said that the main problem used to be mostly alcohol abuse, “but now almost every attorney that comes in for treatment, even if they drink, they are using drugs, too – Xanax, Adderall, opiates, cocaine and crack.”6

ABA Endorses Mindfulness Meditation

The Task Force report recommended numerous ways to improve the well-being of lawyers, judges, and law students. Among these recommendations is mindfulness meditation:

Mindfulness meditation is a practice that can enhance cognitive reframing (and thus resilience) by aiding our ability to monitor our thoughts and avoid becoming emotionally overwhelmed. . . . Research has found that mindfulness can reduce rumination, stress, depression, and anxiety. It also can enhance a host of competencies related to lawyer effectiveness, including increased focus and concentration, working memory, critical cognitive skills, reduced burnout, and ethical and rational decision-making. Evidence also suggests that mindfulness can enhance the sense of work-life balance by reducing workers’ preoccupation with work.” [Citations omitted.]

Can mindfulness really do all that? This article offers an introduction to mindfulness to answer that question and the one in the title of this article. [Sneak preview to the answers: Yes.]

What Is Mindfulness?

According to professor emeritus Jon Kabat-Zinn, the founder of the well-known, well-respected, and well-researched Mindfulness-Based Stress Reduction program, mindfulness is “awareness, cultivated by paying attention in a sustained and particular way: on purpose, in the present moment, and non-judgmentally.”8 Let’s break down the phrases in this definition to see what they each mean.

Focusing Attention – Better Lawyering

What does it mean to pay attention “on purpose”? In our over-scheduled, on-demand, 24/7-connected, and social-media filled world, constant and chaotic distractions have become a major impediment to professional and personal satisfaction. One study found that mind-wandering is very common, occurring on average 47 percent of the time during the day.9 That is a lot of time spent not thinking about what one is doing in the moment of doing it, whether working, writing, reading, talking with others, driving, eating, taking care of children, or whatever. To make matters worse, the study showed that people are less happy when their minds are wandering than when they are fully attentive to what they are doing, however mundane the activity.10

Research has shown that people who practice meditation can remain alert to distractions and return more easily to focused attention when they become aware that their mind has wandered.11 One comprehensive review of mindfulness research concluded that the average meditator had stronger attention skills than 72 percent of non-meditators.12 Related to improving attention control, mindfulness training has also been shown to improve working memory.13 Bringing more focused attention and better working memory to your work can result in greater efficiency and productivity in your professional life, making you a better lawyer – as well as a more resilient one.14

Being Present – Happier Lawyering

What does it mean to pay attention “in the present moment”? Or another way to phrase the question, what is happening when the mind is wandering? When the mind is in its “default mode” (not attending to a task – i.e., when it is wandering or daydreaming), it is likely engaged in one or more of the following mental activities: self-referential processing (i.e., thinking about “I, me, and mine”); mental time travel (e.g., reminiscing, regretting, or ruminating about what happened in the past, or dreading, anticipating,
or fantasizing about what could happen in the future); and making judgments and social comparisons.15

All that mental activity of the mind in its “default mode” when we are not absorbed in a current task can be time-consuming, exhausting, stress-inducing, and unproductive if we are actually trying to get some work done. Mindfulness trains the mind to focus on the present, to notice when it has become distracted, and to gently return focus back to the present. In meditation, the object of focused attention is often the breath. The beginning meditator discovers how often and quickly her mind wanders (usually within seconds), and what a challenge it can be to notice that it has wandered and to return her focus to her experience in the present moment. And the mindfulness practice is to do it over and over again during each “sit” (as meditation practice is often called): as it becomes easier in meditation, it becomes easier in life.

Developing the ability to be fully present in the present moment experience can not only make you a better lawyer, it can also make you a happier lawyer. After all, the mind-wandering study above was titled A Wandering Mind Is an Unhappy Mind. Akin to its findings, well-being theory from the positive psychology field posits that engagement – being completely absorbed and engaged in the present task, whatever it may be – is one of the five key elements of personal well-being.16

Being present to whatever is happening in the here and now is also what helps to develop a balance between your work life and other important parts of your life: family, friends, recreation and hobbies, community service, spiritual activities -- wherever you find additional fulfillment and meaning in your life. Being fully present is what allows you to say, more often than you probably can do today, that “whatever happens at work, stays at work.”

Suspending Judgment – Kinder Lawyering

What does it mean to pay attention “non-judgmentally”? And why would lawyers want to be less judgmental – isn’t that what we are paid to be? To judge the merits of our client’s case? To judge the weaknesses of the other side’s? To deconstruct and then put together complex transactions and litigation? Would mindfulness take the edge off our ability to be successful, zealous advocates for our clients?

Fortunately, mindfulness will not make you less rational, analytical, organized, or hard-working or less energetic in representing your clients (if you have been following along, being less distracted and more present will likely make you a better lawyer). What paying attention non-judgmentally means is becoming less likely to act on your automatic reactions to whatever arises in the present moment and more likely to consider what your appropriate responses might be (e.g., those you will not later regret). Studies have shown that meditators are able to pay attention in a more open, non-reactive way.17

Like everyone else, lawyers have a cognitive negativity bias: humans react more strongly to negative stimuli than to positive ones.18 This bias can be a good thing, for example, when we need to assess risks on behalf of clients or imagine worst-case scenarios in order to avoid them. Our negativity bias can be a harmful thing, however, when combined with our mind’s natural tendency to make judgments about nearly everything – people, places, experiences, things, etc. -- as good (pleasant), bad (unpleasant), or neutral.19 This naturally judging and negative mindset can be amplified by a perfectionism streak common among lawyers, and it can be especially harmful when it is turned inward. It can also be harmful when we develop negative judgments about others and automatically act on them (however well-deserved we think those judgments or actions are).

We are simply hard-wired to make these kinds of judgments to identify perceived threats to ourselves and to sort things, situations, and people into “good” and “bad” categories.20 While this hard-wired negativity and judgment-making may have served our ancestors well millennia ago when they needed to keep vigilant to scan the horizon for actual threats to their survival (from actual saber-tooth tigers), today it keeps us in constant hyper-alertness to our modern-day paper tigers: occupational and psychological stressors in the workplace and interpersonal relationships. Yet our minds and bodies minds experience today’s threats and stressors as just as real and as life-threatening as an actual tiger’s nearby growling. This chronic stress, driven by mental and psychological fears and perceptions, has led to the current crisis in the health and well-being of legal professionals.

Mindfulness is not about suppressing our active minds or jettisoning our negative thoughts and judgmental opinions (that would not be possible anyway). It is about developing a different relationship to them: becoming more aware that they are just thoughts, opinions, and judgments – and not reality. Through meditation – sitting quietly for a period of time trying to focus on one thing and watching how the mind automatically goes to thoughts, opinions, and judgments – one learns how to befriend one’s mind and remain non-reactive to its vicissitudes, meanderings, and ruminations. By becoming more aware and accepting over time of our own mind’s internal workings, we can become kinder and more forgiving of ourselves. By accepting that others’ minds work exactly the same way, we can become kinder and more forgiving of them. Mindfulness is about cultivating a discerning mind, rather than judging mind.21

Wellness and Health

There has been an explosion of scientific research on the effects of mindfulness meditation, literally thousands of articles. Happily, you do not have to read all of them to become acquainted with their conclusions and the benefits of mindfulness meditation, because Georgia Tech Professor Paul Verhaegen has already done so in a recent, readable volume. After carefully reviewing the scientific literature, he observed: “Mindfulness seems to have a positive impact on just about any psychological variable we (as a field) have looked at – it makes you less stressful, boosts your immune function, [and] makes you less anxious and depressed . . . .”22 Since stress, anxiety, and depression were some of the health conditions among lawyers that most concerned the Task Force, this makes mindfulness a promising way to address them.
Wisdom – Professionalism and Ethics

So much scientific research has been on mindfulness meditation’s potential to improve one’s physical and mental health that it is easy to lose sight of its other, primary goals: to promote self-awareness and self-acceptance, foster compassion (for self and others), maintain open-mindedness and curiosity, enhance our ability to relish the here and now (however messy and chaotic), and see reality with clarity and equanimity.25 Mindfulness thus can promote not simply wellness, but also wisdom. Many of these self-reflective traits and skills are foundational to making ethical decisions and reflecting the ideals of professionalism in law.

Judge Jeremy Fogel, Director of the Federal Judicial Center, has explored professionalism in the judicial context and how mindfulness could improve judicial demeanor and functioning. He has written that mindfulness could help judges to, for example, take a thoughtful approach to repetitive tasks, limit their unconscious assumptions, regulate their emotions in stressful situations, and strengthen their capacity for reflective thinking.24 There is new scholarship calling for empirical research to study the potential for mindfulness training to improve ethical reasoning and behavior and reduce bias among legal professionals.25

Scientific evidence already supports that mindfulness meditation can enhance one’s self-awareness and interpersonal relationships, which contribute to wise decisions and actions. Verhaegen found that research shows that mindfulness: “...dampens your negative emotions, amplifies your positive emotions, helps regulate your emotions, makes you less ruminative, takes the edges off negative personality traits, makes you more mindful, strengthens your self-concept, and makes you more empathetic and compassionate.”26

The wellness effects of mindfulness meditation that probably most people are interested in -- stress reduction and mental health improvements -- “are easily acquired and maintained: Just sit!”27 Wisdom will take somewhat longer. Certainly mindfulness is not a cure-all for everything that ails the legal profession. Yet if the research shows that it “makes a person a little bit of a better human being, a little happier, a tad less rough around the edges, and just a bit more pleasant to be around,”28 it is certainly worth giving it a try. For most meditators, the proof is in the pudding: undertaking the actual practice of meditation and discovering its beneficial effects for oneself, personally and directly.

Charity Scott, JD, MSCM, is the Catherine C. Henson Professor of Law at the Georgia State University College of Law. She offers mindfulness training at the law school every fall.

Endnotes
3 Id. at 51.
4 National Task Force report, supra note 1, at 7.
6 Id.
7 National Task Force report, supra note 1, at 52-53.
8 Jon Kabat-Zinn, Mindfulness for Beginners: Reclaiming the Present Moment – And Your Life, at 1 (Sounds True, Inc., 2012).
9 M. Killingsworth & D. Gilbert, A Wandering Mind Is an Unhappy Mind, 330 SCIENCE 932 (Nov. 2010).
10 Id.
13 Id. at 111.
16 M. Seligman, Flourish: A Visionary New Understanding of Happiness and Well-Being (Atria, 2013), at 16-26 (the other four key elements of well-being being are experiencing positive emotions, having a larger sense of meaning/purpose, personal accomplishment, and positive interpersonal relationships).
17 Verhaegen, supra note 12, at 99-102, 114.
19 Id. at 14-15.
21 Kabat-Zinn, supra note 8, at 85-86.
22 Verhaegen, supra note 12, at 136.
23 Kabat-Zinn, supra note 8, at 123-133.
26 Verhaegen, supra note 12, at 136.
27 Id. at 165.
28 Id. at 168.
Charity Scott, JD, MSCM, is the Catherine C. Henson Professor of Law at Georgia State University College of Law. She was the founding Director of the Center for Law, Health & Society, whose health law program has been consistently ranked in the top ten by *U.S. News & World Report*. Scott has taught courses, publishes, and speaks on health law and policy, bioethics, tort law, negotiation, mediation, and mindfulness. A member of the American Law Institute, Scott has served on the Governing Council of the ABA Health Law Section, and as past Chair of the Health Law Section of the State Bar of Georgia. She has been instrumental in developing the mindfulness and wellness programs at Georgia State Law. She graduated from Stanford University (AB), Harvard Law School (JD), and Kennesaw State University (MSCM).
MEDICAL MALPRACTICE LITIGATION: PLAINTIFF’S PERSPECTIVE

James H. Webb, Jr., Webb & Taylor LLC, Peachtree City
MEDICAL MALPRACTICE LITIGATION: DEFENDANT’S PERSPECTIVE

Lindsay A. Forlines, Weathington McGrew LLC, Atlanta
Lindsay A. Forlines

PROFESSIONAL PROFILE
Lindsay has been defending physicians, nurses, hospitals and other healthcare providers against alleged professional negligence since she began practicing law in 2008. During this time, she has gained experience successfully representing medical professionals throughout the litigation process. Lindsay also represents physicians in pre-litigation claims and non-litigation matters, such as investigations by the Georgia Composite Medical Board.

Lindsay graduated Magna Cum Laude from the University of Georgia in 2003 with a degree in Journalism, specializing in broadcast journalism. She attended law school at University of Georgia School of Law, where she graduated in 2008. Lindsay’s proudest law school accomplishment was being selected for the Willis J. “Dick” Richardson Jr. Student Award for Outstanding Trial Advocacy.

From 2012-2015, Lindsay proudly served her hometown as an elected official on the Avondale Estates Board of Mayor and Commissioners. She also served as president of the DeKalb County Municipal Association in 2013. Lindsay is a repeat instructor at the Emory University Kessler-Eidson Program for Trial Techniques, and also a repeat featured speaker and panelist at the Georgia Association for Women Lawyers Leadership Academy. Additionally, Lindsay was a featured speaker at Resurgens Orthopaedics’ 2017 Back-to-Basics Conference, held at St. Joseph’s Hospital.

PRACTICE AREAS
Medical Malpractice Defense
General Liability Defense
BAR & COURT ADMISSIONS
Georgia, 2008
Georgia Supreme Court, 2008
Georgia Court of Appeals, 2008
Northern District of Georgia, 2008

EDUCATION
University of Georgia School of Law, J.D., 2008
University of Georgia, B.A., 2003, magna cum laude
Professional & Community Activities
State Bar of Georgia, Member
Dekalb Bar Association, Member
Georgia Defense Lawyers Association, Member
City of Avondale Estates, Elected Representative (2012-2015)
Dekalb Municipal Association, President (2013)
Georgia Association for Women Lawyers Leadership Academy, Speaker/Panelist
Resurgens Orthopaedic Back to Basics Conference, Speaker (2017)
ICLE, State Bar of Georgia, Medical Malpractice Liability Institute, Co-Chair (2017)
National High School Mock Trial Competition, volunteer judge (2017)
HOSPITAL AFFILIATIONS

Michelle A. Williams, Alston & Bird LLP, Atlanta
W. Wright Banks, Jr., Deputy Attorney General, Georgia Office of the Attorney General, Atlanta
HOSPITAL MERGERS AND ACQUISITIONS AND THE GEORGIA HOSPITAL ACQUISITION ACT

W. Wright Banks, Jr., JD
Deputy Attorney General, Office of the Attorney General

Michelle Williams, JD
Partner, Alston & Bird LLP

FEBRUARY 27, 2019
GEORGIA ICLE
Hospitals keep up swift pace of mergers, alliances

The year is bringing a rash of big hospital deals in Georgia, as health systems look to bulk up in size and add to their medical territory.

The first transaction came a week ago, with the completion of Tennessee-based HCA’s acquisition of Memorial Health in Savannah.

Still pending are three other major combinations.

It will still be called Memorial Health, and the hospital will be operate as Memorial Health University Medical Center. But there are some immediate changes in appearance.

As part of the new system, Memorial’s “orange dot” logo has been replaced by HCA’s “caring star.”
Waycross, GA, Hospital Joins HCA South Atlantic & Reflects 61 Years of Caring for Southeast Georgians in New Name - Memorial Satilla Health

Hospital leadership and its Board of Directors are celebrating the successful integration of the Waycross, GA, hospital into HCA's South Atlantic Division.

Columbus Regional finalizes merger with Piedmont Healthcare

Alyssa Rege - Monday, March 5th, 2018
Atrium Health and Navicent Health Announce Plans to Form Strategic Combination to Serve Communities in Central and South Georgia

Northside and Gwinnett to merge into metro Atlanta hospital giant

Feb 12, 2019
By Ariel Hart, The Atlanta Journal-Constitution
THE GEORGIA HOSPITAL ACQUISITION ACT
O.C.G.A. § 31-7-400 et seq.

- Effective October 31, 1997
- Applies to change of ownership involving the purchase or lease of 50% or more of a nonprofit hospital’s assets
- Includes certain management arrangements
- Includes change of control transactions
- Ultimate goal is to preserve charitable assets

THE BASICS

- Transaction Fully Negotiated and Transaction Documents Complete including Schedules and Valuation/Fair Value Report
- File on Attorney General Form with all Required Documentation
- Attorney General Accepts or Rejects the Filing
- Attorney General Sets a Public Hearing Date and Retains a Financial Advisor
- Interviews/Site Visits
- Public Hearing
- Attorney General Releases Findings in a Report
THE FILING OF THE NOTICE TRIGGERS AG ACTION

- Must give AG at least 90 days notice of the proposed transaction prior to consummation
- AG must publish notice of transaction in county newspaper within 10 days of Notice filing
- AG must conduct a public hearing within 60 days after acceptance of Notice by AG (Not Receipt)
- AG must issue Report of Findings within 30 days of the public hearing

INFORMATION

- Determination Letters
- Reports of Findings
- Notice Forms

On the website: [http://law.ga.gov]

Call for older Reports and Determination Letters
### ACQUISITION ACT REVIEW CRITERIA
O.C.G.A. § 31-7-406

<table>
<thead>
<tr>
<th>Party</th>
<th>Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Seller</td>
<td>1. Whether the disposition is permitted under Chapter 3 of Title 14, the “Georgia Nonprofit Corporation Code,” and other laws of Georgia governing nonprofit entities, trusts, or charities.</td>
</tr>
<tr>
<td>Seller</td>
<td>2. Whether the disposition is consistent with the directions of major donors who have contributed over $100,000.00.</td>
</tr>
<tr>
<td>Seller</td>
<td>3. Whether the governing body of the nonprofit corporation exercised due diligence in deciding to dispose of hospital assets, selecting the acquiring entity, and negotiating the terms and conditions of the disposition.</td>
</tr>
<tr>
<td>Seller</td>
<td>4. The procedures used by the nonprofit corporation in making its decision to dispose of its assets, including whether appropriate expert assistance was used.</td>
</tr>
<tr>
<td>Seller</td>
<td>5. Whether the governing body of the nonprofit corporation exercised due diligence in selecting the acquiring entity, and negotiating the terms and conditions of the disposition.</td>
</tr>
<tr>
<td>Seller &amp; Purchaser</td>
<td>6. Whether the seller or lessor will receive fair value for its assets, including an appropriate control premium for any relinquishment of control, and in the case of a proposed disposition to a not-for-profit entity, an enforceable commitment for fair and reasonable community benefits.</td>
</tr>
<tr>
<td>Seller &amp; Purchaser</td>
<td>7. Whether charitable assets are placed at unreasonable risk if the transaction is financed in part by the seller or lessor.</td>
</tr>
<tr>
<td>Seller &amp; Purchaser</td>
<td>8. Whether the terms of any management or services contract negotiated in conjunction with the transaction are reasonable.</td>
</tr>
<tr>
<td>Seller &amp; Purchaser</td>
<td>9. Whether any disposition proceeds will be used for appropriate charitable health care purposes consistent with the nonprofit corporation’s original purpose or for the support and promotion of health care in the affected community.</td>
</tr>
<tr>
<td>Seller &amp; Purchaser</td>
<td>10. Whether a meaningful right of first refusal to repurchase the assets by a successor nonprofit corporation or foundation has been retained if the acquiring entity subsequently proposes to sell, lease, or transfer the hospital to yet another entity.</td>
</tr>
<tr>
<td>Seller &amp; Purchaser</td>
<td>11. Whether sufficient safeguards are included to assure the affected community continued access to affordable care and to the range of services historically provided by the nonprofit corporation.</td>
</tr>
<tr>
<td>Seller &amp; Purchaser</td>
<td>12. Whether the acquiring entity has made an enforceable commitment to provide health care to the disadvantaged, the uninsured, and the underinsured and to provide benefits to the affected community to promote improved health care.</td>
</tr>
<tr>
<td>Seller &amp; Purchaser</td>
<td>13. Whether health care providers will be offered the opportunity to invest or own an interest in the acquiring entity or a related party, and whether procedures or safeguards are in place to avoid conflict of interest in patient referrals.</td>
</tr>
</tbody>
</table>

### WHAT IS THE STANDARD FOR AG APPROVAL?
- Public interest determination
- Must be adequate disclosure
  - To insure that the transaction is authorized
  - To safeguard the value of charitable assets
  - To insure that proceeds of the transaction are used for appropriate charitable health care purposes
PUBLIC HEARING - PURPOSE

• To provide full disclosure of the purpose and terms of the proposed disposition of the assets of the hospital
• To provide an opportunity for local public input to ensure that the public’s interest is protected when the proposed disposition is completed

CASE LAW

• Can the parties to a transaction sign a Purchase and Sale Agreement prior to submitting the Notice filing?
  • No, the Transaction documents should not be signed prior to AG approval
  • Some parties have entered into a good faith side agreement
REVIEW CRITERIA

• Seller’s Valuation Consultant
  – Prepares a financial and economic analysis
    • Value of hospital as a “going concern”
    • Whether the consideration matches or exceeds that value
    – When not paid in money, need value of consideration
    • Nonprofit to nonprofit — will receive an enforceable commitment for fair and reasonable benefits for its assets.

*The Acquisition Act does not require a fairness opinion*

FREQUENTLY ASKED QUESTIONS:

• Is community benefit a factor in determining value in a not-for-profit to not-for-profit transaction?
  ▪ In a sale to a nonprofit, the seller should receive “an enforceable commitment for fair and reasonable Community benefits for its assets”
  ▪ The use of the word “for” implies an exchange
  ▪ Therefore, the assets to be sold must be valued so that there is some way to measure the fair and reasonable Community benefits
  ▪ Where the seller receives the going concern value of the hospital assets to be sold, the charitable investment in the hospital is not diminished
  ▪ Parties should submit a valuation of the Hospital with its Notice since the value of the Hospital aids in determining whether the Community is receiving a benefit for its assets
COMMON MISTAKES

- Not contacting the Attorney General for a determination when there is a question
- Attempting to file before the Notice is ready or Transaction terms agreed on
- Not filing with sufficient time to close the transaction
- Attempting to execute the sale documents (you may have an unsigned draft) before AG issues report

QUESTIONS?
W. Wright Banks, Jr.
Georgia Office of Attorney General

W. Wright Banks, Jr. is a Deputy Attorney General with the Office of the Georgia Attorney General. He serves as the Director of the Commercial Transactions and Litigation Division which includes three sections: Business and Finance; Real Property, Construction, Transportation and Authorities; and Tax. From 2007 to 2012, he served as the Section Leader of the Business and Finance Section. Prior to the time that he served as Section Leader, he worked in the Business and Finance Section practicing in a number of areas of law, including alcoholic beverage regulation, bankruptcy, insurance, and procurements handling both transactions and litigation matters. He has provided general representation to a number of entities of the State, including the Department of Administrative Services, the Alcohol and Tobacco Division of the Department of Revenue, the Georgia Lottery Corporation, the Financing and Investment Division of the Georgia State Financing and Investment Commission and the Georgia Superior Court Clerks’ Cooperative Authority.

He graduated from the University of Georgia with an A.B. degree in Political Science in 1990. He received his law degree from Mercer University cum laude in 1993 where he was a member of the Mercer Law Review and Phi Kappa Phi and received three American Jurisprudence Awards.

Among other responsibilities, the Commercial Transactions and Litigation Division is charged with administering the responsibilities of the Attorney General under the Hospital Acquisition Act, O.C.G.A. §§ 31-7-400 through 31-7-412. Wright has served in a variety of roles related to a number of hospital transactions including serving as hearing officer in four recent transactions involving hospitals ranging from twenty-five to in excess of three hundred beds.

Michelle A. Williams, JD
Partner

Michelle Williams practices health care law and is a member of the Firm’s Regulatory Health Care Group and the Products Liability Group. Ms. Williams concentrates her practice on the regulatory aspects of health law and handles Medicare/Medicaid termination actions, EMTALA defense and peer review organization hearings, professional agency actions and administrative agency proceedings including those involved in food poisonings and infectious disease look backs. She also works with the Corporate Health Care Practice Group advising on hospital sales and acquisitions, fraud and abuse and Stark, and qui tam actions.

Prior to law school, Ms. Williams completed her Medical Technologist internship at Butterworth Hospital, an affiliate of Michigan State University, where she received a B.S. in microbiology and public health and a B.S. in animal husbandry.

Ms. Williams was a medical technologist at University Hospitals of Cleveland, Lansing General Hospital and Baystate Medical Center and a laboratory assistant at Michigan State University where she worked on vaccine projects for Brucelosis and Marek’s Disease Herpes Virus. While an undergraduate, she worked at the Michigan State University abattoir in all phases of meat production.

She received her J.D. in 1986 from Case Western Reserve University School of Law where she was the Executive Editor of Health Matrix: Quarterly Journal of Health Services Management. Following law school, she served as assistant counsel of University Hospitals of Cleveland, Ohio, a teaching hospital of Case Western Reserve University School of Medicine, and then as associate general counsel of The Mt. Sinai Medical Center, Cleveland, Ohio.

She is a member of the American Health Lawyers Association (AHLA), past Vice Chair of the AHLA Hospitals and Health Systems Practice Group, past Chair of the American Red Cross Blood Services Southern Region Life Board, past Chair of the Board of Directors of the American Red Cross Southern Region Blood Services, and was first selected to Best Lawyers in America 2006.
3:00 THE TOP THREE HEALTHCARE ISSUES FOR VARIOUS SUB-SPECIALISTS

- **Hospitals**
  *Christy D. Jordan,* Southeast Georgia Health System, Brunswick

- **Mental Health**
  *Robert B. Remar,* Rogers & Hardin LLP, Atlanta

- **Long Term Healthcare**
  *Brittany H. Cone,* Hall Booth Smith PC, Atlanta
Top Three Legal Issues Facing Hospitals

Presented by:
Christy D. Jordan
Chief Operating Officer & General Counsel

Top Three Issues

• Physician/Hospital Alignment
• Payor Relationships
• Data Privacy and Security
Physician/Hospital Alignment

• Rise in Physician Employment
• Other Collaboration Models
• Legal Considerations

Physician/Hospital Alignment - Rise in Physician Employment

• Increased complexity of running a physician practice
  • Payor Contracting
  • Electronic Medical Record
  • Quality based initiatives
• Malpractice costs
• Benefit and Lifestyle Considerations
Physician/Hospital Alignment - Other Collaboration Models

- Medical Director Arrangements
- Contracted Services for Entire Service Line

Physician/Hospital Alignment - Legal Considerations

- Stark/Anti-Kickback Statute considerations
  - Key: Document services provided
  - Key: Document fair market value
  - Key: Document need for purchased services
- Malpractice insurance considerations
  - Typically, same policy covers all employed individuals involved in an event
  - Self-Insured Retention Model
  - Peer review vs. Risk Management Functions
- Reimbursement Considerations
  - Provider based status
Payor Relationships

• Healthcare Financing 101
• Changing reimbursement criteria
• Negotiating fair payment rates

Payor Relationships - Healthcare Financing 101

• Medicaid – does not cover costs of care
• Medicare – costs of care covered for some services; not others
• Uninsured – most costs absorbed by hospital system
• Privately Insured – wide variability
Payor Relationships – Changing Reimbursement Criteria

- Increasingly difficult for patients to qualify for care
- Large deductibles more common
- Preauthorization/Post Service Reviews

Payor Relationships – Negotiating Fair Payment Rates

- Leverage counts
- Considerations for contracted physician services (Emergency Room; Anesthesia; Radiology)
- Continuum of Care
Data Privacy and Security

• Criminal Attacks: The New Frontier
• Breaches – The Complex Investigative Process
• Significant Fines, Penalties and Legal Exposure

Data Privacy and Security; Criminal Attacks: The New Frontier

• Ransom Cases
• Cyberterrorists
• Interoperability
Data Privacy and Security; Breaches – The Complex Investigative Process

- Forensic Investigation
- Notifying Patients
- Notifying Government Entities
- Insurance Coverage

Data Privacy and Security; Significant Fines, Penalties and Legal Exposure - 2018

<table>
<thead>
<tr>
<th>Date</th>
<th>Organization</th>
<th>Fine Total</th>
<th>Link to OCR Settlement</th>
</tr>
</thead>
<tbody>
<tr>
<td>February 1, 2018</td>
<td>Fresenius Medical Care North America (FMCNA)</td>
<td>$1,000,000</td>
<td>Risk breaches add up to millions in settlement costs for entity that failed to heed HIPAA's risk analysis and risk management rules</td>
</tr>
<tr>
<td>February 13, 2018</td>
<td>Philips, Inc.</td>
<td>$100,000</td>
<td>Consequences for HIPAA violations don't stop when a business closes.</td>
</tr>
<tr>
<td>June 18, 2018</td>
<td>The University of Texas M.D. Anderson Cancer Center</td>
<td>$4,000,000</td>
<td>Judge rules in favor of OCR and requires a Texas cancer center to pay $4.0 million in penalties for HIPAA violations.</td>
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<tr>
<td>September 30, 2018</td>
<td>Brigham and Women’s Hospital (BWH), and Massachusetts General Hospital (MGH)</td>
<td>$999,000</td>
<td>Unauthorized Disclosure of Patients’ Protected Health Information During ABC Television Filming Results in Multiple HIPAA Settlements Totaling $999,000</td>
</tr>
<tr>
<td>October 16, 2018</td>
<td>Anthem</td>
<td>$15,000,000</td>
<td>Anthem Pays $15 Million in Record HIPAA Settlement Following Largest U.S. Health Data Breach in History</td>
</tr>
<tr>
<td>November 24, 2018</td>
<td>Allergy Associates of Hartford, P.A.</td>
<td>$125,000</td>
<td>Allergy practice pays $125,000 to settle doctors disclosure of patient information to a reporter</td>
</tr>
<tr>
<td>December 6, 2018</td>
<td>Advanced Care Hospitals/Pاحلوٍ</td>
<td>$189,000</td>
<td>Florida contractor physician’s group shares protected health information with unknown vendor without a business associate agreement.</td>
</tr>
<tr>
<td>December 11, 2018</td>
<td>Poppa Springs Medical Center (uninc.)</td>
<td>$155,000</td>
<td>Colorado hospital failed to terminate former employee’s access to electronic protected health information.</td>
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<tr>
<td>December 12, 2018</td>
<td>Cottage Health</td>
<td>$3,000,000</td>
<td>Cottage Health settles Potential Violations of HIPAA Rules for $3 Million.</td>
</tr>
<tr>
<td>2018 TOTAL:</td>
<td></td>
<td>$28,683,400</td>
<td></td>
</tr>
</tbody>
</table>
Questions?
FUNDAMENTALS OF HEALTH CARE LAW

Institute of Continuing Legal Education in Georgia
February, 2019

ISSUES OF SPECIAL IMPORTANCE TO MENTAL HEALTH PROFESSIONALS

Robert B. Remar
Rogers & Hardin LLP
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ISSUES OF SPECIAL IMPORTANCE TO MENTAL HEALTH PROFESSIONALS

Robert B. Remar
Rogers & Hardin LLP
Atlanta, Georgia

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I.

INTRODUCTION

Mental health professionals ("MHP") face special legal challenges not usually encountered by the other health care professions. Unlike physical health care, mental health treatment frequently involves the disclosure of the patient’s most intimate, secret and personal thoughts, fantasies and conduct. MHPs are also called upon to treat patients who, because of mental illness, may have the potential to injure themselves or others.¹ MHPs also have the ability to involuntarily commit patients and to treat them without their consent. The law therefore imposes special obligations on MHPs as it relates to the confidentiality of patient information and the potential personal liability arising out of the conduct of their patients. This paper addresses the challenges that MHPs face in dealing with the patient-therapist privilege, including responding to discovery and requests for information, and the potential liability arising out of the patient-therapist relationship.

II.

THE PATIENT-THERAPIST PRIVILEGE

Unique among the health care professions in Georgia, communications between a patient and a mental health professional are privileged as a matter of Georgia law. O.C.G.A. § 24-5-501, which provides for the attorney-client, spousal, grand jury and state secret privileges, also provides for privileged communications between patient and psychiatrist, psychologist, clinical social worker, clinical nurse specialist in psychiatric/mental health, licensed marriage and family therapist, and licensed

¹ As discussed below, in 2017 the Georgia Court of Appeals decided one case involving patient suicide and another involving a patient killing two persons.
professional counselor. Communications between and among the listed MHPs who are providing psychotherapy to the patient regarding the patient’s communications are also privileged. O.C.G.A. § 24-5-501(a)(8). In Gwinnett Hospital Systems, Inc. v. Hoover, 337 Ga. App. 87, 785 S.E.2d 918 (2016) the issue was whether a grief journal maintained by the plaintiff in a wrongful death suit on the recommendation of a licensed associate professional counselor who was acting as agent of a licensed professional counselor was absolutely privileged. The plaintiff (Hoover) maintained a “grief journal” that she started after it was recommended to her during a counseling session. Hoover attended counseling sessions with a licensed associate professional counselor (“LAPC”) who was supervised outside of the patient’s sessions by a licensed professional counselor (“LPC”). The defendant sought production of the journal claiming that it was not privileged because it was made under the direction of a LAPC and not an LPC and that it did not qualify as a communication within the meaning of O.C.G.A. § 24-5-501(a). The court held that the LAPC was working for and under the direct supervision of the LPC in providing care and treatment to Hoover. The court, analogizing to the attorney-client privilege, found that communications with the agent of a licensed professional counselor are privileged. The court distinguished cases which had addressed communications with individuals such as nurses or attendants who support the qualified professional but were not acting as their agents. The court further found that the contents of the grief journal were communicated to the LAPC as part of the treatment plan and therefore qualified as a privileged communication under the statute.

---

2 The psychologist-patient privilege is also recognized in the Psychology Practice Act, O.C.G.A. § 43-39-16.
Neither the patient nor the MHP may be compelled to disclose privileged communications except in narrowly defined circumstances. Moreover, the MHP has an affirmative duty to assert the privilege on behalf of the patient and has no authority to waive the privilege without patient consent. The obligations imposed by the privilege raise difficult and often conflicting duties for the MHP that are not applicable to other health care professionals.

Among the issues that MHP's and the Courts must wrestle with are: determining when the privilege is applicable; determining when the privilege is deemed waived; determining if there are exceptions to the privilege; responding to requests for records that contain privileged communications or the product of privileged communications; complying with HIPAA’s psychotherapy notes requirements; and resolving conflicting obligations that arise from the duty to maintain privileged communications with duties to the patient and to third parties.3

A. Determining When The Privilege Applies

1. Is Treatment Given Or Contemplated

MHP's frequently act in different roles: treating therapist, retained expert or court appointed evaluator. However, the patient-MHP privilege applies only “to the extent that treatment was given or contemplated.” Mrozinski v. Pogue, 205 Ga. App. 731, 732, 423 S.E.2d 405, 407 (1992) (emphasis omitted) (quoting Massey v. State, 226 Ga. 703, 704, 177 S.E.2d 79, 81 (1970)). Thus, if an individual sees an MHP for a non-treatment related evaluation, such as fitness for duty, fitness for custody or emotional distress damages, no privilege attaches because the patient is not seeking treatment and

---


The confusion that can arise in distinguishing between treatment and evaluation is exemplified by the Supreme Court’s decision in State v. Herendeen, 279 Ga. 323, 613 S.E.2d 647 (2005). Herendeen involved a subpoena served on two licensed psychologists who were treating two children pursuant to a Juvenile Court Order that the children receive therapy. The State sought the treatment records for use in a criminal prosecution against the children’s’ parents. The State argued that since the treatment was not voluntarily sought, the privilege did not apply. The Court of Appeals, citing Lucas v. State, 274 Ga. 640, 645, 555 S.E.2d 440, 446 (2001), concluded that because treatment was given, the privilege applied regardless of whether the treatment was voluntarily sought. Herendeen v. State, 268 Ga. App. 113, 601 S.E.2d 372 (2004), aff’d, 279 Ga. 323, 613 S.E.2d 647 (2005).

The Georgia Supreme Court affirmed. State v. Herendeen, 279 Ga. 323, 613 S.E.2d 647 (2005). The trial court had held that the children’s’ records were not subject to the privilege because the counseling "was done pursuant to court order with express contemplation of recommendations to the court based upon that therapy." Id. at 324,
613 S.E.2d at 649. Noting that Georgia, along with the other 49 States, the District of Columbia and all federal courts protect psychotherapist-patient communications, the Supreme Court held that where "the requisite relationship [between mental health provider] and patient" exists, the privilege applies. Id. at 326, 613 S.E.2d at 650. In contrast “[t]he requisite professional relationship does not exist when the mental health provider is appointed by the court to conduct a preliminary examination to evaluate a person's mental state because, in such a situation, mental health treatment is not given or contemplated.” Id. In addition, “no professional relationship is formed because no mental health treatment is given or contemplated when a court . . . orders a plaintiff in a tort action to undergo a psychiatric examination . . . or . . . orders persons involved in a parental rights' termination action to undergo a mental evaluation.” Id.

However, the Court rejected the argument that the privilege exists only when the patient voluntarily seeks treatment. Rather, the defining test for whether the privilege exists is whether treatment (as opposed to evaluation or assessment) was provided or contemplated. Because treatment was provided in Herendeen, the privilege applied and the communications between the children and the mental health professional were privileged. The Court remanded to the trial court for a determination of whether there was any material contained in the records that did not originate in communications between the children and their mental health providers and to determine whether a guardian ad litem should be appointed to decide whether the children should invoke the privilege.

The Herendeen decision was applied by the Court of Appeals in a contentious child custody dispute case. Gottschalk v. Gottschalk, 311 Ga. App. 304, 715 S.E.2d 715 (2011). The trial court ordered Mr. Gottschalk to enter therapy with a specified
psychologist. After six sessions the psychologist was directed to issue a report to the
children’s guardian ad litem with respect to continuation of supervised visitation. In
issuing its order the trial court stated:

There is to be no privilege with regard to this therapy as it is
court-ordered and is ordered for the benefit of the minor
children in this matter as well as the [appellant]. [The
therapist] may share the results of this therapy with the
guardian ad litem and the court, and the [appellant] is
specifically required to follow the recommendations of [the
therapist] as a condition of his visitation.

Id. at 315, 715 S.E.2d at 724. The Court of Appeals agreed with Mr. Gottschalk
that the trial court erred when it concluded that the privilege did not apply because the
treatment was court-ordered. Because the court-ordered relationship with the therapist
involved or contemplated treatment, Mr. Gottschalk’s communications with the
therapist were privileged. However, the Court concluded that the error was harmless
because the therapist was directed to only report her conclusions regarding visitation to
the guardian ad litem and the court and not the communications themselves. The Court
did not address the fact that the therapist’s conclusions were necessarily the product of
the privileged communications.

2. Does The Privilege Extend To Communications With A
Physician

Another area of potential confusion is whether the privilege extends to a
physician who does not practice the specialty of psychiatry. Georgia law does not
contain a statutory definition of the term “psychiatrist,” and there is no separate
licensing designation for psychiatrists. The Georgia Supreme Court considered the issue
in Wiles v. Wiles, 264 Ga. 594, 448 S.E.2d 681 (1994). Wiles was a child custody
dispute. The wife, Dr. Wiles, was a physician. The husband sought the medical records
of one of Dr. Wiles’s patients. Dr. Wiles was an internist who testified that she treated
one-third of her patients for mental health problems, that providing counseling was part
of her practice, and that she had treated the patient in question for a mental condition.
The Court concluded that Dr. Wiles was a physician who spent a substantial portion of
her time treating mental and emotional problems and that the privilege was therefore
applicable. Id. at 598, 448 S.E.2d at 684. The difficulty with the Wiles test is that it is
an after-the-fact assessment based upon the nature of the physician’s practice and the
amount of time that the physician devotes to mental health treatment during any
particular time. Thus, a patient may confide in her physician only to learn after the fact
that the communications are not privileged because of the nature of the physician’s
practice.

**B. Determining When The Privilege Is Waived**

Under Georgia law, the patient-MHP privilege is not waived when a plaintiff puts
his/her mental state in issue, for example, by claiming damages for emotional distress
or pain and suffering. Brown v. Howard, 334 Ga. App. at 186, 778 S.E.2d at 813, citing
App. 9, 303 S.E.2d 134 (1983); see also Aetna Cas. & Sur. Co. v. Ridgeview Inst., Inc.,
some federal courts have reached a different result.⁴

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⁴ In Jaffee v. Redmond, 518 U.S. 1 (1996), the Supreme Court resolved a conflict among
the circuits by holding that confidential communications between a licensed
psychotherapist and patient in the course of diagnosis and treatment are protected from
However, when a party calls his or her mental health professional to testify when the party’s mental status is at issue, this constitutes a clear intent to waive the privilege. *Trammel v. Bradberry*, 256 Ga. App. 412, 568 S.E.2d 715 (2002). Also see *Griggs v. State*, 241 Ga. 317, 245 S.E.2d 269 (1978) (defendant who called his psychiatrist to bolster his insanity defense waived the privilege); see also *Armstead v. State*, 293 Ga. 243, 744 S.E.2d 774 (2013) (defendant waived state constitutional right of privacy and statutory privilege in his mental health records when he filed notice of intent to pursue defense of not guilty by reason of insanity and put his mental capacity at issue).

In contrast, in *Neuman v. State*, 297 Ga. 501, 773 S.E. 2d 716 (2015) (the “Dunwoody Day Care” case) the court held that merely raising an insanity defense does not waive the attorney-client privilege as it relates to MHPs engaged to evaluate the defendant’s mental state. In order to evaluate his client’s mental state at the time of the shooting, Neuman’s defense counsel engaged a psychologist and a psychiatrist to evaluate Neuman. The MPH then provided reports to defense counsel. The State sought to obtain the MHP’s records of their evaluation of Neuman. The trial court ordered the records turned over to the State. The Supreme Court reversed, holding that because the doctors were engaged by defense counsel to aid in his representation of Neuman, the attorney-client privilege protected both Neuman’s communications to the doctors and the doctors’ reports to counsel. The Court noted that the doctors were retained to evaluate a possible insanity defense and not as testifying experts. If they had been called to testify the privilege would have been waived.

In the absence of an express waiver of the privilege, one seeking the disclosure of privileged communications must establish a waiver by decisive, unequivocal conduct reasonably showing the intent to waive the privilege. *Mincey v. Ga. Dep’t of Cmtv.*
Affairs, 308 Ga. App. 740, 708 S.E.2d 644 (2011). Mincey was a personal injury action against the Department of Community Affairs (“DCA”). Mincey failed to disclose her prior mental health treatment in response to various discovery requests. As a discovery sanction the court held that Mincey had waived her mental health privilege and ordered Mincey to execute a release authorizing the disclosure of her mental health records.

The Court of Appeals reversed, holding that Mincey’s discovery conduct did not constitute a decisive and unequivocal waiver of the privilege. While the Court held that the trial court erred in concluding that Mincey had waived the privilege, the Court did find that DCA was entitled to discovery of information regarding whether and when Mincey was treated for mental health related issues. This finding was based on the well established rule that the privilege protects communications, not the fact of treatment or the dates of treatment.

In addition, the failure to object to an O.C.G.A. § 9-11-34 third party request for production of psychiatric records does not waive the privilege. Hopson v. Kennestone Hosp., 241 Ga. App. 829, 526 S.E.2d 622 (1999). In connection with a dispute over a divorce settlement agreement, the former husband served a § 9-11-34 discovery request on Kennestone Hospital seeking his ex-wife’s psychiatric records. The ex-wife did not object and the hospital subsequently produced the records to the ex-husband. Kennestone later sued the ex-wife for $704 for medical expenses. The ex-wife counterclaimed asserting various tort theories based on the improper release of the psychiatric records. The trial court granted summary judgment to Kennestone on the counterclaim, relying on Price v. State Farm Mutual Automobile Insurance Co., 235 Ga. App. 792, 510 S.E. 582 (1998). In Price, the Court held that the failure to object to a third party discovery request constituted a waiver of the privilege. Overruling Price, the
Courtheld that because communications between a patient and a psychiatrist are absolutely privileged, the failure to object to a non-party discovery request is not a waiver of the privilege. In order to waive the privilege, the patient must take an affirmative step, such as calling the mental health professional as a witness. Here the failure to object waived only objections to the non-privileged portions of the record.

The Supreme Court affirmed. *Kennestone Hosp. v. Hopson*, 273 Ga. 145, 538 S.E.2d 742 (2000). The Court emphasized the strong public policy behind the privilege and held that the failure to object was not the type of decisive and unequivocal conduct that justifies inferring an intent to waive the privilege.

It is also well established that the presence of a third party not necessary for the treatment process waives the privilege. However, the privilege extends to participants in joint therapy sessions, such as family therapy and marital therapy. There is no waiver of the privilege where persons are being treated jointly or are participants in therapy which is primarily for the benefit of another. *See Odom v. Odom*, 291 Ga. 811, 814, 733 S.E.2d 741, 744 (2012) (“Communications between a treating psychologist and a patient are privileged . . . and do not lose their privileged status because patients may have been treated jointly or because they were referred by a guardian ad litem.”); *Mrozinski v. Pogue*, 205 Ga. App. 731, 423 S.E.2d 405 (1992); *Brown v. Howard*, 334 Ga. App. at 186, 778 S.E.2d at 814.

C. **The Privilege Survives Death**

The strength of the privilege under Georgia law is demonstrated by the Supreme Court’s opinion in *Cooksey v. Landry*, 295 Ga. 430; 761 S.E.2d 61 (2014). Twenty-two year-old Christopher Landry had been under the care of Dr. Cooksey, a psychiatrist, for several years before he committed suicide in September 2012. His parents began
investigating a potential malpractice claim against Dr. Cooksey. They requested Christopher’s psychiatric records from Dr. Cooksey, who refused to produce the records on the basis of the patient-psychiatrist privilege.

The Landreys then filed an action seeking an injunction directing Dr. Cooksey to turn over the records. They argued that without the records they would be unable to adequately investigate a potential claim against Dr. Cooksey. The trial court agreed and, without reviewing the record, ordered Dr. Cooksey to provide all of Christopher’s psychiatric records to the Landreys. The Supreme Court reversed.

The Court first discussed the strength of the privilege under Georgia law, including that the privilege is not waived even though the patient’s care and treatment may be at issue and that the privilege can only be waived by the express action of the patient. 295 Ga. At 432-433. Most importantly, the Court affirmed earlier decisions that the privilege survives death and that a deceased patient’s representative cannot waive the privilege. The Court then reversed, directing the trial court to review the files to determine whether there is any non-privileged information and whether, as to privileged information, there was a waiver by Christopher. In reaching its conclusion the Court emphasized the nature of the privilege under Georgia law:

We conclude by emphasizing that it is no small matter for a court, given its focus on the pursuit of truth and justice, to hold that potentially relevant evidence is shielded from disclosure. Our legislature, however, has determined that the public policies supporting the creation of a mental health privilege necessitated enactment of a nearly absolute privilege, one without exception if the patient is deceased or the nature of the patient’s mental condition is put at issue. As explained by the United States Supreme Court when it recognized a psychiatrist-patient privilege under its own federal evidentiary rules,

If the purpose of the privilege is to be served, the participants in the confidential conversation “must be
able to predict with some degree of certainty whether particular discussions will be protected. An uncertain privilege, or one which purports to be certain but results in widely varying applications by the courts, is little better than no privilege at all.”

*Jaffee v. Redmond* (citations omitted). Likewise, to allow a trial court, through the exercise of its equitable powers and its own notion of what is right, to require disclosure of privileged communications would bring uncertainty to Georgia’s well-defined psychiatrist-patient privilege and eviscerate its effectiveness. The interests protected by O.C.G.A. § 24-5-501 are weighty and cannot simply be set aside in even the most sympathetic of circumstances to allow individuals to search through psychiatric records with the hope of discovering evidence.

*Id.* at 435-436.

In its opinion in *Cooksey*, the Court cited *Sims v. State*, 251 Ga. 877, 311 S.E.2d 161 (1984). In *Sims* the defendant wife was on trial for the murder of her husband and sought to introduce statements made by the deceased husband during joint counseling sessions which both she and her deceased husband had attended. The Court found that the defendant and her husband were jointly seeking counseling for marital problems and that the deceased husband was a necessary participant in the sessions. As a result, the husband’s communications to the psychiatrist were entitled to protection. *Id.* at 881, 311 S.E.2d at 165-66. Since the privilege survives the death of the communicant, there was no one who could waive the privilege and the Court found that the trial court did not err in refusing to allow the psychiatrist to testify as to the deceased victim’s communications during marital therapy. *Id.*

In *Alvista Healthcare Center, Inc. v. Miller*, 286 Ga. 122, 122, 686 S.E.2d 96, 97 (2009), a surviving spouse requested copies of her deceased husband’s medical records because she was investigating a potential wrongful death action involving a nursing care
facility owned and operated by Alvista. Alvista denied the surviving spouse’s requests for records on the basis that HIPAA and its accompanying privacy regulations provided that the records could only be released to a permanent executor or administrator of the deceased spouse’s estate, which was not represented when the widow requested the decedent’s medical records. [See Part II, Section E for a discussion of HIPAA requirements.]

The Georgia Supreme Court held that O.C.G.A. § 31-33-2(a)(2) authorizes a surviving spouse to act on behalf of the decedent or his estate in obtaining medical records only if an executor or an administrator has not been appointed and, therefore, the surviving spouse was entitled to access the decedent’s protected health information under 45 C.F.R. § 164.502(g)(4) of the HIPAA Privacy Rule, which looks to the applicable state law to determine who has authority to act on behalf of the decedent or his estate.5 Alvista Healthcare Center, 286 Ga. at 123-24, 686 S.E.2d at 97. However, the Court specifically stated that under O.C.G.A. § 31-33-4, mental health records are excepted from the provisions of the Health Records Act.

D. Responding To Discovery Requests

Another area that presents potential minefields to MHPs is responding to discovery requests. O.C.G.A. § 9-11-26(b)(1) provides that “[p]arties may obtain discovery regarding any matter, not privileged, which is relevant to the subject matter involved in the pending action.” Therefore, the service of a subpoena, notice to produce discovery or deposition notice does not, by itself, constitute an exception to the

5 Section 164.502(g)(4) requires a covered entity like Alvista to treat a person who has authority to act on behalf of a deceased individual or his estate under an applicable law as a “personal representative . . . with respect to protected health information relevant to such personal representation.” 45 C.F.R. § 164.502(g)(4).

In addition, records maintained by mental health facilities under the Mental Health Code “shall be produced in response to a valid subpoena or order of any court of competent jurisdiction, except for matters privileged under the laws of this state.” O.C.G.A. § 37-3-166(a)(8) (emphasis added); O.C.G.A. § 37-4-125(a)(8). See also O.C.G.A. § 37-7-166(a)(7) (relating to treatment records of alcoholics and drug dependent individuals). Therefore, MHPs may not disclose privileged communications nor produce records containing privileged materials but must assert the patient-MHP privilege. Cooksey v. Landry, 295 Ga. 430, 761 S.E.2d 61 (2014).


6 Absent the consent of the patient, records of a drug and alcohol abuse treatment facility can be disclosed only by court order following notice and hearing based upon the determination that other ways of obtaining the information are not available and that the public interest and need for disclosure outweigh the harm to the patient, the physician-patient relationship and the treatment service. See 42 C.F.R. § 2.64 (new version effective 2-17-17); see also Carr v. Farmer, 213 Ga. App. 568, 445 S.E.2d 350 (1994).
response to a third party request for production of documents on the fifteenth day after receipt of the request. With three justices vigorously dissenting, the Court affirmed the jury verdict in favor of the psychiatrist on the basis of expert testimony that the standard of care required production of the records because no objection had been filed by the patient. \textit{Id.} at 896, 434 S.E.2d at 828. The decision is questionable given the Court of Appeals and Supreme Court opinions in \textit{Hopson v. Kennestone Hospital, Inc.}, 241 Ga. App. 829 (1999), \textit{aff'd}, 273 Ga. 145, 538 S.E.2d 742 (2000). \textit{See} p. 8, supra. In \textit{Hopson}, a tort claim was asserted against Kennestone for releasing Sherri Hopson’s psychiatric records. The Court of Appeals reversed the trial court’s grant of summary judgment to Kennestone, finding that Hopson’s failure to object to a O.C.G.A. § 9-11-34 request for production of records did not constitute a waiver of the patient-psychiatric privilege. The Supreme Court granted certiorari and affirmed. \textit{See also Bala v. Powers Ferry Psychological Assocs.}, 225 Ga. App. 843, 491 S.E.2d 380 (1997) (concluding that an expert affidavit opining that a psychologist had improperly disclosed information concerning the plaintiff to the plaintiff’s former husband’s attorney was sufficient to state a claim for malpractice); \textit{Jones v. Thornton}, 172 Ga. App. 412, 323 S.E.2d 217 (1984) (patient sued a physician for invasion of privacy and libel on the basis of compliance with a discovery request prior to the expiration of the objection period provided in the Civil Practice Act). \textit{Accord Sletto v. Hosp. Auth.}, 239 Ga. App. 203, 521 S.E.2d 199 (1999).

\textbf{E. HIPAA Protection For Psychotherapy Notes}

\textbf{1. HIPAA And Protected Health Information.}

HIPAA’s Privacy Standards, 45 C.F.R. § 164.500, \textit{et seq.}, generally prohibit “covered entities” from using or disclosing “protected health information” (“PHI”),
unless a specific exception in the Privacy Standards applies. Moreover, state laws that are more stringent than the Privacy Standards in protecting medical and health information are not preempted. Therefore, the strong protection that Georgia law affords to the patient-therapist privilege is not diluted by HIPAA.

A “covered entity” generally may not use or disclose covered health information, except: (1) for treatment, payment, or health care operations; (2) upon the individual’s agreement in certain limited circumstances (after an opportunity to agree or object); (3) to the individual; (4) pursuant to an authorization from an individual (unless the authorization is for the use or disclosure of genetic information for underwriting purposes); or (5) as permitted or required by HIPAA for governmental or other purposes. 45 C.F.R. § 164.502(a). Even when the use or disclosure of PHI is permitted, in most circumstances, a “minimum necessary” disclosure standard applies. 45 C.F.R. § 164.502(b).

HIPAA has an expansive definition of protected “health information.” It applies to oral or recorded information that is created or received by a health care provider or plan and that relates to the past, present, or future health or condition of an individual, the provision of health treatment to an individual, or payments for health treatments. 42 U.S.C. § 1320d(4). Thus, even enrollment forms, claim forms, and bills for medical treatment include protected health information.

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2. **Consent vs. Authorization.**

The Privacy Rules do not generally require that a covered entity obtain patient consent for use and disclosure of protected health information for specified purposes, including treatment, payment, and health care operations. See 45 C.F.R. § 164.502. (One notable exception is for psychotherapy notes, discussed below.) Nevertheless, the regulations permit and encourage health care providers to obtain consent for such purposes. The requirements for patient consent are set forth generally in Section 164.506.

By contrast, an “authorization” is required by the Privacy Rules for uses and disclosures of protected health information not otherwise permitted, even with consent. An authorization is a detailed document that gives covered entities permission to use protected health information for specified purposes other than treatment, payment, or health care operations, or to disclose protected health information to a third party specified by the individual. Where the Privacy Rules require patient authorization, voluntary consent is not sufficient to permit a use or disclosure of protected health information unless it meets the Privacy Rules’ requirements for a valid authorization.

A valid authorization must specify a number of elements, including, but not limited to, (1) a specific description of the protected health information to be used and disclosed, (2) the person authorized to make the use or disclosure, (3) the person to whom the covered entity may make the disclosure, (4) the purpose of the disclosure, (5) an expiration date, (6) the right to revoke authorization (with certain limited exceptions); (7) a statement regarding the ability or inability to condition treatment, payment, enrollment or eligibility on the authorization; and (8) the potential for additional disclosure by the recipient. See 45 C.F.R. § 164.508.
In *Allen v. Wright*, 282 Ga. 9, 644 S.E.2d 814 (2007), the Georgia Supreme Court held that the medical release authorization requirement of O.C.G.A. § 9-11-9.2 is preempted by HIPAA. Section 9-11-9.2 requires that, in any action alleging medical malpractice, the plaintiff is required to file a medical authorization form which authorizes defendant’s counsel to obtain and disclose protected health information and to discuss the plaintiff’s case and treatment with his/her treating physicians. The Court concluded that the required authorization does not satisfy HIPAA requirements because it does not contain a sufficiently specific identification of the information to be disclosed, does not provide for an expiration date, and does not contain a notice of the right to revoke the authorization. The 9-11-9.2 authorization was therefore preempted by HIPAA and not enforceable. See also *Northlake Med. Ctr., LLC v. Queen*, 280 Ga. App. 510, 634 S.E.2d 486 (2006).

In *Gerguis v. Statesboro HMA Medical Group*, 331 Ga. App. 867, 772 S.E. 2d 227 (1995), the Court addressed a dispute over access to patient medical records. Statesboro HMA purchased a physician practice group. Under the purchase agreement HMA owned the records. When members of the physician practice group left to start their own practice they requested access to the patient records, which HMA declined to provide except upon a HIPAA compliant patient authorization. The Court of Appeals sided with HMA. The Court first noted that personal medical records are protected by the Georgia constitutional right to privacy and cannot be disclosed except by patient consent or as otherwise required by law. The Court then concluded that under HIPAA HMA, as the custodian of the records, could only disclose the records pursuant to a valid patient authorization even if the patient had previously seen the requesting physician.
3. **Psychotherapy Notes.**

In addition to the general protections for PHI, HIPAA's Privacy Rule extends special protection to psychotherapy notes. 45 C.F.R. § 164.508(a)(2) states that “[n]otwithstanding any provision of this subpart, . . . a covered entity must obtain an authorization for use or disclosure of psychotherapy notes . . .” (emphasis added).

“Psychotherapy notes” are defined as:

[Notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. Psychotherapy notes excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: Diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.]

45 C.F.R. § 164.501 (emphasis added). Therefore, psychotherapy notes should be maintained in a separate file from the rest of the patient’s record.

The regulations provide that, with limited exceptions (which exceptions do not apply to psychotherapy notes), a covered entity “may not condition the provision to an individual of treatment, payment, enrollment in the health plan, or eligibility for benefits on the provision of an authorization.” 45 C.F.R. § 164.508(b)(4).

The regulations recognize several exceptions to the authorization requirement for psychotherapy notes. See 45 CFR § 164.508(a)(2). Those exceptions include:

- Use by the originator of the psychotherapy notes for treatment;

- Use or disclosure by the covered entity in training programs in which students, trainees, or practitioners in mental health learn under supervision to practice or improve their skills in group, joint, family, or individual counseling;

- Use or disclosure by the covered entity to defend a legal action or other proceeding brought by the individual;
• Use with respect to the oversight of the originator of the psychotherapy notes, such as peer review;

• Disclosures required by law (45 C.F.R. § 164.512(a)) and certain disclosures about decedents (45 C.F.R. § 164.512(g)); and

• Disclosures required to avert a serious threat to health or safety. 45 C.F.R. § 164.512(j).


In response to the tragedies at Newtown, Connecticut and Aurora, Colorado, the Director of the Office for Civil Rights of the Department of Health and Human Services (DHHS) confirmed in a January 15, 2013 open letter to the nation’s health care providers that HIPAA’s privacy rules (45 C.F.R. § 164.512(j)) allow for the disclosure of “necessary information about a patient to law enforcement, family members of the patient, or other persons, when [the provider] believe[s] the patient presents a serious danger to himself or other people.” Open Letter from Leon Rodriguez, Director of Office of Civil Rights for the Department of Health and Human Services, to United States Health Care Providers (January 15, 2013), http://www.hhs.gov/ocr/office/lettertonationhcp.pdf. The letter notes that disclosure is allowed to any “persons whom the provider believes are reasonably able to prevent or lessen the threat,” including “the police, a parent or other family member, school administrators or campus police, and others who may be able to intervene to avert harm.” See Section III, C. 3 regarding liability for warning.

Additionally, Section 164.512 specifically allows disclosures to “[a] public health authority or other appropriate government authority authorized by law to receive reports of child abuse or neglect.” 45 C.F.R. § 164.512(b)(1)(ii); see also 45 C.F.R. § 160.203(a)(iv) and (c) (HIPAA’s confidentiality provisions do not preempt state laws
that provide “for the reporting of disease or injury [or] child abuse”); O.C.G.A. § 19-7-5 (requiring MHPs to report child abuse). Section 512(c) allows a health provider to report other suspected abuse, but places limitations on such reporting. It states that:

Except for reports of child abuse or neglect permitted by paragraph (b)(1)(ii) of this section, a covered entity may disclose protected health information about an individual whom the covered entity reasonably believes to be a victim of abuse, neglect, or domestic violence to a government authority, including a social service or protective services agency, authorized by law to receive reports of such abuse, neglect, or domestic violence:

(i) To the extent the disclosure is required by law and the disclosure complies with and is limited to the relevant requirements of such law;

(ii) If the individual agrees to the disclosure; or

(iii) To the extent the disclosure is expressly authorized by statute or regulation and:

(A) The covered entity, in the exercise of professional judgment, believes the disclosure is necessary to prevent serious harm to the individual or other potential victims; or

(B) If the individual is unable to agree because of incapacity, a law enforcement or other public official authorized to receive the report represents that the protected health information for which disclosure is sought is not intended to be used against the individual and that an immediate enforcement activity that depends upon the disclosure would be materially and adversely affected by waiting until the individual is able to agree to the disclosure.

(2) Informing the individual. A covered entity that makes a disclosure permitted by paragraph (c)(1) of this section must promptly inform the individual that such a report has been or will be made, except if:

(i) The covered entity, in the exercise of professional judgment, believes informing the individual would place the individual at risk of serious harm; or

(ii) The covered entity would be informing a personal representative, and the covered entity reasonably believes the personal representative is responsible for the abuse, neglect, or other injury and that informing such person would not be in the best interests of the individual as determined by the covered entity, in the exercise of professional judgment.

45 C.F.R. 164.512(c).
4. **Individuals’ Rights To Access Protected Health Information.**

HIPAA’s Privacy Standards provide an individual with the right to inspect and obtain copies of his/her protected health information. That right, however, is not unqualified. A covered entity may refuse to disclose psychotherapy notes to the patient without any right of review under 45 C.F.R. § 164.524(a)(1). Moreover, access to other protected health information may be denied if the health care professional exercising his/her professional judgment determines that granting the patient “the access requested” would “reasonably likely” endanger the life or physical safety of the individual or another person. However, the patient has a right to have such a denial reviewed by a licensed health care professional who is designated by the covered entity as a reviewing official and who did not participate in the initial decision to deny. 45 C.F.R. § 164.524(a)(3)(i).

The Georgia Mental Health Code\(^8\), on the other hand, grants patients access to their entire mental health record, including psychotherapy notes. Specifically, under the Mental Health Code, current patients may examine all their mental health records unless the Chief Medical Officer or the treating physician or psychologist determines that disclosure of the record would be detrimental to the patient’s physical or mental health and a notation of that determination is included in the patient’s record. O.C.G.A. §§ 37-3-162(b) and 37-3-167(a); Ga. Comp. R. & Regs. § 290-4-6-.05(3)(a). Former patients, however, have unqualified access to their mental health records and the

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\(^8\) O.C.G.A. § 37-3-101 et seq.
exception for withholding on the basis of potential harm is not applicable. Ga. Comp. R. & Regs. § 290-4-6-.05(3)(a).9

Georgia law has no similar statutory provisions for mental health professionals in the private practice setting to assist them in determining what rights patients have to access their mental health records. The Georgia Composite Board of Professional Counselors, Social Workers, and Marriage and Family Therapists has adopted rules as part of the Code of Ethics which state, in part, that licensees must “provide information regarding a client’s evaluation or treatment, in a timely fashion and to the extent deemed prudent and clinically appropriate by the licensee, when that information has been requested and released by the client.” Ga. Comp. R. & Regs. § 135-7-.01(2)(m).

Therefore, professional counselors, social workers, and marriage and family therapists follow a standard that is similar to the rules governing mental health facilities.10

Georgia courts have not considered the question of whether mental health professionals must follow HIPAA or Georgia law when assessing patients’ rights of access to their protected health information. HIPAA and its related regulations do not preempt any state law that provides more stringent requirements for the access of protected health information. Alvista Healthcare Ctr., 286 Ga. at 126, 686 S.E.2d at 99 (citing Moreland v. Austin, 284 Ga. 730, 733, 670 S.E.2d 68, 71-72 (2008)); Allen v. Wright, 282 Ga. 9, 12, 14, 644 S.E.2d 814, 816-18 (2007). According to 45 C.F.R. § 160.202, a state law is more stringent if it provides the patient greater rights of access to

9 Importantly, Georgia law does not address the question of whether a mental health professional may refuse a former patient access to mental health records if the mental health professional determined that releasing those records would be detrimental to the former patient’s mental or physical health.

10 The Rules of the State Board of Examiners of Psychologists do not directly address the patient’s right of access to his/her records but, by implication, a patient does have a right of access. Ga. Comp. R. & Regs § 510-4-.02(e)(4.05).
his/her protected health information. See Moreland v. Austin, 284 Ga. at 733, 644 S.E.2d at 71 (“More stringent’ means laws that afford patients more control over their medical records”); Tender Loving Health Care Serv. of Ga., LLC v. Ehrlich, 318 Ga. App. 560, 734 S.E.2d 276, 279 (Ga. Ct. App. 2012) (HIPAA preempts state law when it “affords patients more control over their medical records”) overruled on other grounds by Wellstar Health Sys., Inc. v. Jordan, 293 Ga. 12, n. 6, 743 S.E.2d 375 (2013) (holding in part that HIPAA did not entitle an individual to access protected work product in the possession of a covered entity simply by virtue of the fact that it contained protected health information). Section 164.524(a)(1) of the HIPAA rules allows a covered entity to deny a patient complete access to psychotherapy notes without specifying a reason and without the requirement for review of the decision. However, under the Georgia Mental Health Code, current patients of a mental health facility have an absolute right of access to their entire mental health records, unless a mental health professional determines that disclosure of any portion of the records would harm the patient mentally or physically. O.C.G.A. §§ 37-3-162(b) and 37-3-167(a); Ga. Comp. R. & Regs. § 290-4-6-.05(3)(a). Therefore, when current patients request their mental health records, including psychotherapy notes, a Georgia facility may only withhold psychotherapy notes if there is a finding that disclosure would be detrimental to the patient.

In contrast, former patients have an unfettered right of access to their records maintained by the facility. Ga. Comp. R. & Regs. § 290-4-6-.05(3)(a). There is thus a potential conflict between the HIPAA provisions which provide no right of access to psychotherapy notes and the Mental Health Code, which clearly grants a right of access. Since the Mental Health Code provides the patient with greater rights than are provided by HIPAA, the Mental Health Code would likely preempt HIPAA’s provision permitting
a facility to deny a patient right of access to psychotherapy notes. This conflict should not be an issue in the context of current patients, since access can be denied if it is determined that access would be detrimental to the patient. While the state regulations grant a former patient access without exception, the Code Section (O.C.G.A. § 37-3-162 (b)) provides for access subject to a finding of potential harm and makes no distinction between current and former patients. Since the primary duty imposed on any health care professional is to do no harm, the prudent course of action would be for a mental health professional in charge of patient records at a facility to review those records to determine whether disclosure to the patient would likely cause harm to the patient. If it is determined in good faith that disclosure would likely cause the patient harm, then the record should not be disclosed (and a notation to that effect should be made in the patient’s record).

As to mental health professionals in private practice, other than licensed professional counselors, social workers and marriage and family therapists, there are no statutes or rules specifically governing a patient’s right of access to their records. Since HIPAA explicitly provides that a mental health professional may refuse to disclose psychotherapy notes to the patient, the prudent course of action would be for the mental health professional to determine whether disclosure of psychotherapy notes to the patient or to any other entity that the patient requests would be detrimental to the patient. If so then those portions of the record which could cause the patient harm should be withheld. If there is no likelihood of harm then the mental health professional would have no reason not to provide the records to the patient.
5. **No Private Right Of Action under HIPAA**

HIPAA’s penalty provisions authorize the Secretary of Health and Human Services to impose significant monetary penalties for any violation of the Act.\(^\text{11}\) The civil monetary penalty escalates based on the provider's increasing level of culpability. Any person that violates HIPAA is liable for a penalty ranging from $100 to $50,000 per violation (where the covered entity did not know of the violation and would not have known of it with the exercise of due diligence) to a minimum of $50,000 per violation (where the violation was due to willful neglect and was not corrected in a timely fashion). The total amount imposed on the person for all violations of an identical requirement or prohibition during a calendar year may not exceed $1,500,000.

While the civil monetary penalties can be substantial, the federal courts have found that HIPAA does not create a private right of action. In *Acara v. Banks*, 470 F.3d 569 (5th Cir. 2006), the Fifth Circuit affirmed the dismissal on subject matter jurisdiction grounds of an action against a physician for the unconsented disclosure of medical information during a deposition. The Court found that HIPAA’s delegation of enforcement authority to the Secretary of Health and Human Services was strong evidence of Congress’s intent to preclude private enforcement. Every other Circuit Court that has analyzed the issue has come to the same conclusion. See *Miller v. Nichols*, 586 F.3d 53, 59 (1st Cir. 2009) (“No Private Right of Action under HIPAA”); *Carpenter v. Phillips*, 419 F. App’x 658, 659 (7th Cir. 2011) (“HIPAA does not furnish a private right of action”); *Dodd v. Jones*, 623 F.3d 563, 569 (8th Cir. 2010) (“HIPAA does not create a private right of action”); *Seaton v. Mayberg*, 610 F.3d 530, 533 (9th Cir.

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\(^{11}\) HIPAA’s penalty provision now incorporates the increased and tiered civil money penalty structure provided by the Health Information Technology for Economic and Clinical Health (HITECH) Act.

**Issues Related To Workers’ Compensation**

Although Section 164.508(a)(1) requires authorization before a covered entity may use or disclose protected health information, there is an exception for disclosure for use in a workers’ compensation proceeding. Under Section 164.512, a covered entity may use or disclose protected health information without written authorization or an opportunity to object “as authorized by and to the extent necessary to comply with laws relating to workers’ compensation or other similar programs . . .” 45 C.F.R. § 164.512(l). Similarly, the regulations allow disclosures to an employer to evaluate whether an individual has a work-related illness, 45 C.F.R. § 164.512(b), or to determine eligibility
for government benefits, 45 C.F.R. § 164.512(d). Thus, as a general matter, PHI may be disclosed to determine eligibility for benefits.

In addition, with respect to workers’ compensation, O.C.G.A. § 34-9-207(a) provides that “[w]hen an employee has submitted a claim for workers’ compensation benefits . . . , that employee shall be deemed to have waived any privilege or confidentiality concerning any communications related to the claim or history or treatment of injury . . . , including, but not limited to, communications with psychiatrists or psychologists.” In other words, by submitting a claim for workers’ compensation benefits, an employee waives any claim of privilege or confidentiality he may have with regard to his medical records under Georgia law to the extent that they relate to his claim. See Arby’s Rest. Group, Inc. v. McRae, 292 Ga. 243, 244, 734 S.E.2d 55, 56-57 (Ga. 2012) (“The occurrence of any one of [the] triggering events [in O.C.G.A. § 34-9-207] waives the employee’s privilege in confidential health information”). Therefore, given the Privacy Rule’s incorporation of state law when addressing workers’ compensation, a covered entity is generally permitted to disclose an individual’s protected health information related to a workers’ compensation claim without prior authorization.

However, as previously noted, the Privacy Rule extends special protection to psychotherapy notes (45 C.F.R. § 164.508(a)(2)). Although several provisions of 45 C.F.R. § 164.512 are specifically exempt from the authorization requirement (§ 164.512(a), (d) as it relates to oversight of the health care provider, (g)(1) and (j)(1)(i)), Section 164.512(l)—addressing workers’ compensation—is not among them. 45 C.F.R. § 164.508(a)(2)(ii). Moreover, although on its face the “disclosures required by law” provision might seem to apply, the specific discussion of disclosures allowed under this
provision would not appear to cover workers’ compensation proceedings, particularly in light of the specific workers’ compensation provision contained in Section 512(l).

Therefore, using basic rules of construction, it appears that psychotherapy notes may not be disclosed without authorization in a workers’ compensation proceeding because workers’ compensation is not one of the listed exceptions under Section 508(a)(2)(ii).

III.
DAMAGES CLAIMS PARTICULARLY RELEVANT TO MENTAL HEALTH PROFESSIONALS

A. Involuntary Detention / False Imprisonment

The Georgia Code defines false imprisonment as “the unlawful detention of the person of another, for any length of time, whereby such person is deprived of his personal liberty.” O.C.G.A. § 51-7-20. The Georgia Court of Appeals provided a good statement of the elements of the tort in Hampton v. Norred & Associates, Inc.:

The essential elements of the cause of action for false imprisonment are a detention of the person of another for any length of time, and the unlawfulness of that detention. A detention need not consist of physical restraint, but may arise out of words, acts, gestures, or the like, which induce a reasonable apprehension that force will be used if plaintiff does not submit; and it is sufficient if they operate upon the will of the person threatened, and result in a reasonable fear of personal difficulty or personal injuries. . . . A person need not make an effort to escape or to resist until an application of open force results, thereby risking possible physical injury, before he can recover; however, an actual detention must have occurred whether caused by force or fear.

216 Ga. App. 367, 368, 454 S.E.2d 222, 223 (1995) (citations omitted). The tort thus has two central elements: (1) detention of the person (for any length of time), and (2) unlawfulness of the detention. Scott Hous. Sys., Inc. v. Hickox, 174 Ga. App. 23, 24, 329 S.E.2d 154, 155 (1985) (“In an action to recover damages for . . . false imprisonment the only essential elements are the arrest or detention and the unlawfulness thereof.”)
(citation omitted). Cases alleging false imprisonment by mental health professionals generally focus on the “unlawfulness” of the detention.

A mental health professional who in good faith executes a procedurally valid certificate authorizing involuntary detention under the Georgia Mental Health Code does not act “unlawfully” and is insulated from a false imprisonment claim. Williams v. Smith, 179 Ga. App. 712, 715, 348 S.E.2d 50, 53 (1986). The Williams court, relying on the immunity provisions of the Mental Health Code for the admission and release of patients under O.C.G.A. § 37-3-4, applied a two-part test to determine a psychiatric clinic’s immunity from a false imprisonment claim. First, so long as a patient’s detention is predicated upon procedurally valid process, the detention is not “unlawful,” and the remedy of false imprisonment is unavailable. Second, even if the detention is secured by procedurally void or defective process, false imprisonment is available only if the process was secured in bad faith. Id.

O.C.G.A. § 37-3-4 provides civil and criminal immunity to a person authorized to involuntarily commit patients so long as she “acts in good faith in compliance with the admission and discharge provisions of this chapter” and does not “fail[] to meet the applicable standard of care in the provision of treatment to [the] patient.” This immunity provision provides an affirmative defense that the defendant has the burden

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12 O.C.G.A. § 37-3-41 allows any physician, psychologist, clinical social worker, or clinical nurse specialist in psychiatric/mental health within the state to execute a certificate stating that he has personally examined a person within the preceding forty-eight hours and found that the person appears to be a mentally ill person requiring involuntary treatment. O.C.G.A. § 37-3-81 allows for the involuntary detention of a patient beyond the evaluation period upon recommendation of the chief medical officer of an evaluating facility supported by the opinions of two physicians or a physician and a psychologist who have personally examined the patient within the preceding five days and who agree that the patient is a mentally ill person requiring involuntary treatment.

Heath reached the Court of Appeals twice. In its first review, the Court reversed summary judgment in the defendants’ favor on the plaintiff’s false imprisonment claim because the defendants produced no evidence that the plaintiff’s three-day detention was pursuant to valid procedural process. Heath v. Peachtree Parkwood Hosp., Inc., 200 Ga. App. 118, 119, 407 S.E.2d 406, 407 (1991).

Upon remand, the plaintiff argued she was not a voluntary patient who could be lawfully detained against her volition. The patient testified that she believed she was checking herself into a weight loss clinic and that she was never notified of her statutory rights as a voluntary mental health patient and thus had no knowledge that she was, instead, checking into a mental health facility in which she could be held against her will. The jury returned a verdict of $25,000 on the false imprisonment claim in the plaintiff’s favor.

On appeal, the defendants asserted as an affirmative defense that they were immune from liability, as provided by O.C.G.A. § 37-3-4, because they acted in good faith in compliance with the admission and discharge provisions of the statutes governing the admission of voluntary patients to a mental health facility. The Court held that, in order to assert the affirmative defense of immunity under O.C.G.A. § 37-3-4, the defendants first had to show the plaintiff was, in fact, a voluntary patient subject to the Mental Health Code. The Court held that the trial court did not err in instructing
the jury that the defendants had the burden of proving these facts and upheld the jury verdict in the plaintiff’s favor. Heath v. Emory Univ. Hosp., 208 Ga. App. at 631-32, 431 S.E.2d at 429-30.

The affirmative defense of immunity provided under O.C.G.A. § 37-3-4 does not extend to hospitals or other mental health facilities, but only to the employees of such entities. Krachman v. Ridgeview Inst., Inc., 301 Ga. App. 361, 687 S.E.2d 627 (2009). In Krachman, the plaintiff conceded that she was lawfully admitted to Ridgeview as a voluntary patient, but she contended that she was unlawfully detained after Ridgeview staff members did not comply with the discharge procedures under O.C.G.A. § 37-3-22(a). Reversing the trial court’s grant of summary judgment in favor of the mental health facility, the Court held that the plain language of O.C.G.A. § 37-3-4 extends immunity only to designated individuals and “does not evidence a legislative intent to confer immunity on hospitals or other mental health facilities.” Id. at 364, 687 S.E.2d at 629. Furthermore, because the plaintiff sued Ridgeview under a respondeat superior theory of liability, Ridgeview had no defense based on its agent’s immunity from civil liability for acts committed in the course of employment as “[i]mmunities, unlike privileges, are not delegable and are available as a defense only to persons who have them.” Id. at 364, 687 S.E.2d at 630 (quoting Gilbert v. Richardson, 264 Ga. 744, 754, 452 S.E.2d 476, 483-84 (1994) (citing Restatement (Second) of Agency § 217(b)(ii) (1958))). Finally, the Court found that material issues of fact existed as to plaintiff’s false imprisonment claim. Because there was evidence that the plaintiff orally expressed her desire for discharge to Ridgeview staff members on numerous occasions, the Court concluded that jury questions remained regarding whether Ridgeview demonstrated its “objective compliance” with the discharge procedures set forth in O.C.G.A. § 37-3-22 (a).

In addition to compliance with procedural requirements, Georgia law provides a defense to a false imprisonment claim based on the existence of a medical emergency or the consent of a substituted decision maker. In Davis v. Charter-By-The-Sea, Inc., 183 Ga. App. 213, 358 S.E.2d 865 (1987), two adult children brought their intoxicated mother to the hospital. The mother had to be bodily carried by her children due to her condition, and two doctors who attended her determined she was “medically unstable” and should be admitted. One of the children also signed a consent form authorizing treatment of her mother.

The Court, distinguishing Williams because that case involved delivery of a patient to a facility by a peace officer pursuant to a valid certificate, found evidence of “other legal justification for receiving, examining, and treating [the mother].” 183 Ga. App. at 216, 358 S.E.2d at 868. The Court found sufficient evidence in the record to support a defense to the plaintiff’s false imprisonment charge based on (1) the existence of a medical emergency and (2) valid consent given by a substituted decision maker or the implied consent of the incapacitated plaintiff. Id. at 216-17, 358 S.E.2d at 868.

B. Unauthorized Disclosure Of Privileged Records

Georgia law recognizes a cause of action for damages for the breach of the duty to protect a patient’s privacy and confidentiality. See generally Mrozinski v. Pogue, 205 Ga. App. 731, 423 S.E.2d 405 (1992); Orr v. Sievert, 162 Ga. App. 677, 292 S.E.2d 548 (1982). In Mrozinski, a father participated in the psychiatric treatment of his minor daughter. The father contended that the treating psychiatrist provided privileged information to the attorney of his former wife for use in a custody suit. The information
provided included a “discharge summary” and an affidavit. The information described the father’s conduct and reactions during family therapy, contained the psychiatrist’s observations and conclusions as to the interaction between the father and his daughter during family therapy, and expressed negative criticism of the father's conduct and reactions during therapy. The affidavit recommended that custody of the child be returned to the former wife.

The father claimed (1) wrongful disclosure of privileged information, and (2) breach of confidential relations for both his and his daughter’s records. The psychiatrist contended that the father was not a patient, and thus no privilege existed between himself and the father, and that any communications lost their privileged status when the psychiatrist treated the father and daughter jointly. The psychiatrist also argued that the father lacked standing to raise these claims on behalf of his minor daughter.

Referencing strong public policy interests, the Court held that if multiple persons participate in joint therapy, the psychiatrist-patient privilege extends to the communications of all participants. Mrozinski, 205 Ga. App. at 733, 423 S.E.2d at 408. The Court held that genuine issues of material fact existed, precluding summary judgment, on whether the psychiatrist gave or contemplated psychiatric assistance to the father so that the father would be a patient and the privilege would exist, and on whether the psychiatrist breached a confidential relationship during the custody dispute and disclosed the father’s privileged information. Id. at 734, 423 S.E.2d at 409. The Court also held that the father had standing to file suit for unauthorized disclosure of his minor daughter's clinical records and for unauthorized release of privileged material regarding his minor daughter. Id. at 736-37, 423 S.E.2d at 411.
Georgia law also recognizes a claim for invasion of privacy for the unauthorized disclosure of privileged records. The right of privacy in Georgia is a “fundamental constitutional right.” *Cornelius v. Hutto*, 252 Ga. App. 879, 883, 558 S.E.2d 36, 40 (2001) (citations omitted). To bring a successful invasion of privacy claim, a plaintiff must prove: (1) the defendant made a disclosure to the public; (2) the facts disclosed were private, secluded or secret facts and not public ones; and (3) that the matter made public was offensive and objectionable to a reasonable man of ordinary sensibilities under the circumstances. *Cabaniss v. Hipsley*, 114 Ga. App. 367, 372, 151 S.E.2d 496, 501 (1966). For a thorough discussion of the right to privacy under Georgia law, including public records that may contain privileged communications, see Phillips v. Consol. Publ’g Co., Civil Action No. CV 213-069, 2015 WL 5821501 (S.D. Ga. Sept. 14, 2015).

*Cornelius* is one of the few Georgia cases involving an invasion of privacy claim against a mental health professional. In *Cornelius*, a father brought a breach of confidentiality and invasion of privacy action against his former psychiatrist for giving an affidavit regarding custody of his son. Before the father divorced his ex-wife, the psychiatrist had treated them both. The allegedly offending affidavit did not expressly mention the psychiatrist’s treatment of the father, but concluded that the son “would best be served by having limited contact with his father,” and that “[the ex-wife] is the more psychologically fit and nurturing parent . . . .” *Cornelius*, 252 Ga. App. at 880-81, 558 S.E.2d at 39.

The Court found sufficient evidence in the record to send the question of breach of confidentiality to the jury, and thus upheld the denial of a directed verdict in the
father’s favor. Id. at 882-83, 558 S.E.2d at 39-40. On the invasion of privacy claim, the Court rejected the defense that because the communications were revealed in an affidavit filed with the Court they were privileged under O.C.G.A. § 51-5-8 (providing a limited privilege in defamation cases). Citing “strong public policy against releasing mental health records,” the Court refused to allow “circumvent[ion]” of the psychiatrist-patient privilege merely by filing an affidavit in a lawsuit. Id. at 883-84, 558 S.E.2d at 40-41. The Court thus held that the father’s invasion of privacy claim presented a jury question, and reversed a directed verdict in the psychiatrist’s favor. Id.

C. Patient Causes Harm to Third Parties

Georgia law creates seemingly conflicting duties on mental health professionals regarding the duty to warn identifiable third parties of foreseeable potential harm from a patient. On the one hand, Georgia law places a well-established duty on mental health professionals to maintain the confidentiality of patient communications. Mrozinski v. Pogue, 205 Ga. App. 731, 423 S.E.2d 405 (1992); Orr v. Sievert, 162 Ga. App. 677, 292 S.E.2d 548 (1982); see also supra, Part II, Section B. On the other hand, Georgia law imposes duties on mental health professionals both to their patients and to third parties that may require the disclosure of confidential and privileged communications. Under some circumstances, the duty to warn an identifiable third party of potential harm from a patient may outweigh the mental health professional’s obligation to maintain the privileged and confidential nature of patient communications.

13 The father contended that testimony by the psychiatrist at trial contradicted the psychiatrist’s affidavit and should therefore have been excluded, entitling the father to a directed verdict. The Court held that the testimony did not necessarily contradict the affidavit, and, even if it did, additional evidence in the record supporting the psychiatrist’s defense precluded granting a directed verdict in the father’s favor. Id. at 882-83, 558 S.E.2d at 39-40.
1. Duty To Control

Georgia courts have not explicitly adopted the classic duty to warn concept set forth in the seminal case of Tarasoff v. Regents of University of California, 551 P.2d 334 (Cal. 1976), superseded by statute as stated in The Regents of the Univ. of California v. Superior Court of Los Angeles Cty., 29 Cal. App. 5th 890, 903, 240 Cal. Rptr. 3d 675, 686 (Ct. App. 2018), reh’g denied (Dec. 21, 2018), review filed (Jan. 14, 2019).

Nevertheless, the Georgia courts have held that a duty to prevent harm to others may arise out of the special nature of the therapist/patient relationship. At the very least, mental health professionals in Georgia have a duty to exercise reasonable care to control a patient to prevent him from doing bodily harm to a third person. Bradley Ctr., Inc. v. Wesner, 161 Ga. App. 576, 287 S.E.2d 716, aff’d, 250 Ga. 199, 296 S.E.2d 693 (1982).

In Bradley Center, the patient of a mental health facility shot and killed his ex-wife and her lover while the patient was on an unrestricted weekend pass from the hospital. The hospital argued that it owed no duty to the ex-wife because she was outside the professional-client relationship. The Court disagreed, holding that where the course of treatment of a mental patient involves an exercise of control over him by a physician who knows or should know that the patient is likely to cause bodily harm to others, an independent duty arises, requiring the physician to exercise that control with such reasonable care as to prevent the patient from causing harm to others. Id. at 581, 287 S.E.2d at 721.

In 1992, the Georgia Court of Appeals described the Bradley Center decision as establishing a “two-part test” for determining under what circumstances a physician may be liable to a third party: “(1) the physician must have control over the mental patient; and (2) the physician must have known or reasonably should have known that
the patient was likely to cause bodily harm to others.” Ermutlu v. McCorkle, 203 Ga. App. 335, 336, 416 S.E.2d 792, 794 (1992). Thus, Bradley Center is expressly limited to cases in which the mental health professional has taken charge or otherwise assumed control of the patient. As such, if no right of control exists, a plaintiff cannot state a claim. See generally Ward v. Emmanuel Cty. Bd. of Health, 218 Ga. App. 382, 461 S.E.2d 559 (1995); Ermutlu, 203 Ga. App. 335, 416 S.E.2d 792 (1992). For example, a mental health professional cannot be held liable for the release of a voluntary outpatient, since the professional does not exercise control over such a patient. Id. at 337, 416 S.E.2d at 794-95 (holding that patient must meet involuntary commitment standard before psychiatrist’s duty arises).

In Curles v. Psychiatric Solutions, Inc., 808 S.E.2d 237 (2017) the Georgia Court of Appeals reversed a dismissal of plaintiff’s wrongful death action alleging ordinary and medical negligence against the owners, operators and employees of a psychiatric treatment facility that treated and released a patient who later killed two persons. The case arose from the deaths of Donna Kern and William Chapman at the hands of Amy Kern. Amy Kern had an extensive mental health history dating back to 1999 and she suffered from psychotic episodes which resulted in violent conduct. Between November 2008 and January 2009 Amy was an involuntary patient at Focus by the Sea, a private psychiatric facility, on three separate occasions. Her first involuntary commitment came after she attempted suicide. She remained at Focus for ten days and upon release she voluntarily sought outpatient psychiatric treatment. A month later she was arrested after she chased her boyfriend around their home with an axe. As a condition of her release from custody she was ordered to return to Focus for psychiatric treatment, where she remained for seven days. Seven days later she was involuntarily committed
for a third time after threatening violence against her boyfriend. 14 days after her commitment she was discharged from Focus and 12 days later she killed her grandmother and her aunt’s boyfriend.

Count II of the Complaint alleged that Focus and its employees failed to comply with the statutory notification and discharge requirements pursuant to O.C.G.A. §§ 37-3-4, 37-3-24 and 37-3-95. The trial court dismissed that Count on the basis that it sounded in medical malpractice and that it was barred by the medical malpractice statute of repose and the expert affidavit requirement. The Court of Appeals reversed, finding that the underlying negligent or wrongful act upon which Count II was based did not arise out of care or treatment for the benefit of Amy nor did it involve the exercise of professional judgment. Rather, it arose out of a statutory duty to give notice. The Court further found that the allegations of the Complaint were sufficient to establish that the victims were within the class of individuals that the notice provision was designed to protect.

Count III of the Complaint was based upon the duty to control principal enunciated in the Bradley Center case. Given Amy’s repeated instances of violence and the fact that she was involuntarily committed to the care of Focus were sufficient to establish both a special relationship between Focus and Amy and that she posed a threat of danger to herself and others. The Court then reversed the trial court on the basis that it had erred in construing Count III as a claim for medical malpractice. The Court found that the allegations of the Complaint that Amy was discharged based on a corporate policy of releasing patients when their insurance ran out, did not sound in malpractice.
2. Duty To Warn

The Georgia Court of Appeals has addressed a second exception to the general rule that a doctor has no duty to prevent a third person from harming others. That exception “requires a special relationship between the doctor and the injured party which would confer a right to protection to the injured party.” Bruscato v. Gwinnett-Rockdale-Newton Cmtv. Serv. Bd., 290 Ga. App. 638, 640, 660 S.E.2d 440, 443 (2008) (citing Gilhuly v. Dockery, 273 Ga. App. 418, 419, 615 S.E.2d 237, 239 (2005); Restatement (Second) of Torts § 315(b)).

Bruscato involved a psychiatric patient who was being cared for and monitored at home, at his parents’ request and upon condition that the parents would provide 24-hour monitoring of the patient. The patient ultimately killed his mother, and the patient’s father sued the patient’s treating psychiatrist, alleging, in part, that the psychiatrist had a duty to the mother by virtue of the mother’s special relationship with the psychiatrist. Id. at 641, 660 S.E.2d at 443. Relying on Swofford v. Cooper, 184 Ga. App. 50, 360 S.E.2d 624 (1987), aff’d, 258 Ga. 143, 368 S.E.2d 518 (1988), the father contended that the mother “was conferred ‘patient-like’ status and had privity with [the

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14 The comments to Section 315 indicate that such relationships would include, for example, common carriers, innkeepers, possessors of land, and individuals who are required by law or who voluntarily take custody of another. Bruscato, 290 Ga. App. at 642 n.7, 660 S.E.2d at 444 n.7. “[T]he comments to [Section 315] suggest that special relationships are based upon a duty to control.” Id.

15 Swofford presented the issue of whether a patient’s caretakers became “patients” of the defendant physician by receiving advice as to how best to assist with the patient’s care. Swofford, 184 Ga. App. at 53, 360 S.E.2d at 627. Citing Sims v. State, 251 Ga. 877, 881, 311 S.E.2d 161, 165 (1984), wherein the Supreme Court of Georgia held that when a third-party family member participates in joint therapy sessions, the third party is a "necessary or customary participant" and is deemed a patient to whom the privilege applies, the Court of Appeals concluded that the caretakers were not patients because they did not “necessarily or customarily participate[] in the consultation and treatment of [the patient].” Swofford, 184 Ga. App. at 53, 360 S.E.2d at 627.
treating psychiatrist] since she ‘necessarily [and] customarily participated in the consultation and treatment of [the patient].’” Bruscat, 290 Ga. App. at 641, 660 S.E.2d at 443 (citation omitted). The Court of Appeals rejected both the “patient-like status” argument and the privity argument, concluding that no special relationship existed between the treating psychiatrist and the mother. Id. at 641-42, 660 S.E.2d at 443-44. The Court rejected the argument, as had the Swoford court, that the mere taking of advice regarding the treatment of a patient can convert a caretaker into a patient. Id.

The Bruscat court also rejected the argument that the mother had been in privity of contract with the psychiatrist by virtue of her agreement with the psychiatrist to provide 24-hour supervision and that this privity gave rise to a special relationship. Distinguishing cases in which decedent patients had sued physicians and hospitals based on duties to aid or protect arising from privity of contract, the Court refused to extend that privity to a “third party who was never the patient of the physician or hospital.” Id. at 642, 660 S.E.2d at 444. The Court, accordingly, declined to extend the duties owed to third parties beyond that set forth in Bradley Center based on the facts of Bruscat, wherein the parents had supervised the patient at home for over three years prior to the attack. Id. at 643, 660 S.E.2d at 444. The Court stated further policy bases for its reticence, noting first that “[e]xtending a physician's duty of care to third parties beyond the provisions of the Bradley Center test mandating that the physician exercise control over the patient could discourage outpatient care to the detriment of the state's express policy of providing the ‘least restrictive alternative,’ ‘least restrictive environment,’ or ‘least restrictive appropriate care and treatment’ to mental patients.” Id. The Court further noted that “the imposition of liability for an outpatient under these circumstances could discourage physicians from including the relative of any
mental health patient—or for that matter, the relative of a minor—in the treatment process out of concern that the physician would be exposed to greater liability.”  Id. Finally, the Court held that there was no duty to warn the mother of dangers and tendencies of which she was already fully aware by virtue of her care for the patient.  Id. at 643-44, 660 S.E.2d at 445. Interestingly, Bruscatò made a second appearance in the Court of Appeals in 2010. As discussed at page 41 below, the patient sued his psychiatrist for malpractice alleging claims for emotional distress. The Court reversed the dismissal of the case holding, in part, that the impact rule was not applicable to emotional distress claims in medial malpractice actions.

The Court of Appeals had addressed similar issues in Jacobs v. Taylor, 190 Ga. App. 520, 379 S.E.2d 563 (1989), a case in which the Court of Appeals appeared to assume that an assertion of breach of duty to warn identifiable parties of a patient’s threats of violence stated an claim for relief. Jacobs involved a patient (Murray) who killed his ex-wife and two strangers five months after his release from a state hospital to the county jail. Following his acquittal on terroristic threat charges, Murray was released from custody and two months later murdered Taylor’s decedents. The children of the decedents brought suit alleging, inter alia, that the defendants-physicians breached a duty to warn the decedents of their patient’s murderous tendencies. The Court upheld summary judgment in favor of the physicians, finding that the ex-wife “was fully cognizant of the danger [the patient] presented,” and that Georgia law imposes no duty to warn of that which the plaintiff already knew or should have known. Id. at 527, 379 S.E.2d at 568 (citations omitted). The Court found that the two strangers to the patient were not “foreseeable or readily identifiable targets.” Id. The Court noted that it would not “impose a blanket liability on the doctors for failing to warn members
of the general public . . . of the risk posed by . . . a patient with a history of violence who made generalized threats . . .” Id.

3. Liability For Warning

Since Georgia has yet to specifically adopt the duty to warn under Tarasoff, a mental health professional could potentially face liability to the patient for breach of the duty of privacy and confidentiality if she does warn a third party of harm. Furthermore, even if Georgia law imposes a duty to warn third parties on mental health professionals, many open issues concerning the application of the duty remain. For example, is an “express threat” required before the duty is triggered as it is in several other jurisdictions? Is “imminent danger” required?

In at least one case, Garner v. Stone, a jury returned a substantial damages award for a plaintiff who alleged the defendant-psychologist’s decision to warn a third party of harm posed by the patient breached the psychologist’s duty of care to the plaintiff. The psychologist made his decision to warn after consultation with an attorney, who informed him that he did have such a duty. The jury returned the verdict against the psychologist notwithstanding instructions informing the jury that a psychologist incurs an obligation to use reasonable care to protect the intended victim if the psychologist determines, pursuant to the standards of his profession, that the patient presents a “serious danger of violence.” The case settled before appeal and therefore serves no precedential value in Georgia.

Given the proliferation of mass shootings, it is likely that, when squarely presented with the issue, the Georgia courts will find that a mental health professional has a duty to warn readily identifiable targets of her patient’s threats of bodily harm

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even if the information was acquired in the course of a privileged communication. As discussed above, the Office of Civil Rights within HHS has affirmed in an open letter to the health community that the HIPAA privacy rules allow an MHP to warn of a readily identifiable threat, even if that warning discloses protected health information. While HIPAA does not preempt state law, it is persuasive public policy. Mental health professionals must therefore make a judgment as to whether the risk to a third party outweighs the patient’s right to privacy.

4. Liability For Emotional Distress

In 2010, the Georgia Court of Appeals carved out an exception in medical malpractice actions to the rule prohibiting recovery for emotional distress damages in negligence actions in the absence of physical injury. In Bruscato v. O’Brien, 307 Ga. App. 452, 705 S.E.2d 275 (2010), aff’d, 289 Ga. 739, 715 S.E.2d 120(2011), the Court of Appeals concluded that a plaintiff alleging medical malpractice no longer has to show physical injury to recover for emotional distress caused by the alleged malpractice. The Court also ruled that the plaintiff was not barred by public policy from pursuing a malpractice claim against his psychiatrist even though the alleged malpractice ultimately led to the plaintiff murdering his mother. Also see Howell v. Normal Life of Ga., 337 Ga. App. 774, 788 S.E.2d 840 (2016).


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17 New York has amended its mental hygiene law by providing that if a mental health professional determines that a patient is likely to engage in conduct that would result in serious harm to the patient or others, the professional shall make a report which can be used to revoke the patient’s firearms license or make him ineligible for a license. New York Secure Ammunitions and Firearms Enforcement (SAFE) Act of 2013, S. 2230 (signed Jan. 15, 2013).
(2008), discussed at pages 36-37. Bruscato killed his mother after the defendant psychiatrist discontinued certain prescriptions, allegedly causing the patient to revert into a psychotic, homicidal state. Bruscato’s father, as guardian, filed a malpractice action against the psychiatrist seeking damages for the emotional distress resulting from the alleged negligence in discontinuing his son’s medication. The trial court granted summary judgment to the psychiatrist, concluding that 1) Georgia’s Impact Rule barred the medical malpractice claim, and 2) that the patient could not recover damages due to Georgia’s longstanding public policy of prohibiting wrongdoers from profiting from their misdeeds. On appeal, the Court of Appeals reversed.

The Court of Appeals outlined the origins of the Impact Rule, highlighting the concerns in emotional distress cases of frivolous litigation and the difficulties in proving causation between the negligence and the distress. The Court concluded that “[t]he above-stated policy concerns, however, are not present in medical malpractice cases.” 307 Ga. App. at 457, 705 S.E.2d at 280. According to the Court, the requirements of medical malpractice claims, especially the presence of a physician-patient relationship and O.C.G.A. § 9-11-9.1’s expert affidavit requirement, provide built-in safeguards to these policy concerns. Id.¹⁸

The fact that Bruscato was mentally incompetent to stand trial and had not yet been convicted of a crime was central to the Court’s decision not to invoke Georgia’s longstanding policy of prohibiting wrongdoers from benefiting from their wrongdoing. The Court concluded that Bruscato had not yet been found guilty of murder and, even if found competent to stand trial, could still be found not guilty by reason of insanity. Moreover, Bruscato claimed distress arising from the alleged malpractice—not the

¹⁸ The same rationale would apply to other mental health professionals.
murder—so that “even if Bruscato is characterized as an intentional ‘wrongdoer,’ his status as such would not be a bar to his recovering for those damages that are not attributable to the alleged immoral or illegal act.” Id. at 459, 705 S.E.2d at 281.

The Supreme Court granted certiorari to determine whether the Court of Appeals properly ruled that Bruscato’s damages claims were not barred by public policy barring a wrongdoer from profiting from his wrongful acts. The Court affirmed, adopting the Court of Appeals analysis. O’Brien v. Bruscato, 289 Ga. 739, 715 S.E.2d 120 (2011). The Court concluded that while one who knowingly commits a wrongful act cannot use the act for personal gain, an individual’s psychiatric condition may preclude him from knowingly committing a wrongful act. Because Bruscato had been found incompetent to stand trial, there had not been a finding that he knowingly committed a wrongful act. The Court also noted that Bruscato was not seeking to profit from the murder of his mother; rather, he was seeking damages for the suffering the alleged malpractice caused him. 19

In summary, Bruscato v. O’Brien effectively abrogates the Impact Rule in the medical malpractice context. Moreover, wrongful acts by the plaintiff do not necessarily provide an absolute bar to recovery where the Complaint alleges that the emotional distress arose from the malpractice and not from the wrongful act itself and/or the plaintiff did not knowingly commit the wrongful act.

D. Patient Suicide And Harm To Self

19 A Superior Court in Connecticut recently followed Bruscato holding that lack of mental capacity to commit a crime can be an exception to the wrongful conduct rule. Tonucci v. Gaylord Hosp., Inc., No. CV13602144, 2015 WL 6405691 (Conn. Super. Ct. Sept. 22, 2015).
Unlike third-party-harm claims, which involve non-patients, suicide cases are based on a duty of care to the patient. Georgia first recognized liability for patient suicide in 1933. See Emory Univ. v. Shadburn, 47 Ga. App. 643, 643, 171 S.E. 192, 193 (1933) (holding that hospital has duty to “safeguard[] and protect[] the patient from any known or reasonably apprehended danger from himself . . . and to use ordinary and reasonable care to prevent it”), aff’d, 180 Ga. 595, 180 S.E. 137 (1935). Until recently—and for the same reasons as articulated in the third-party cases—liability for suicide claims in Georgia was predicated on the mental health professional’s right to “control” the conduct of his or her patient and thereby prevent the suicide. See Keppler v. Brunson, 205 Ga. App. 32, 33, 421 S.E.2d 306, 307 (1992) (citing Ermutlu, 203 Ga. App. 335, 336, 416 S.E.2d 792 (1992), for proposition that control required for liability in suicide claim). A 2012 decision by the Georgia Court of Appeals, however, casts doubt on the former “control” standard and suggests that an MHP can be liable for suicide claims under any circumstance, regardless of control, where the treatment of the patient “fell below the requisite standard of care, and this failure proximately caused [the] injury.” Peterson v. Reeves, 315 Ga. App. 370, 375, 727 S.E.2d 171, 175 (2012) (citing O.C.G.A. § 51-1-27).

In Peterson, the patient, Reeves, brought a medical malpractice action against one of her treating psychiatrists for injuries sustained in a suicide attempt. Id. at 370, 727 S.E.2d at 172. During a tumultuous month of involuntary and voluntary treatments for psychotic behavior, Reeves was admitted for a second time to a voluntary treatment facility where Peterson, the psychiatrist, diagnosed her with several mental disorders and prescribed medication. Three days later, and without additional contact with Peterson, Reeves was discharged from the facility. Two days later she poured gasoline
over herself and set herself on fire. Id. at 371-372, 727 S.E.2d at 173. Surviving the attempt, Reeves alleged that Peterson committed malpractice by failing to subject her to a suicide or self-injury risk assessment and for failing to involuntarily commit her. Id. at 372, 727 S.E.2d at 173. Peterson moved for summary judgment, asserting first that “Georgia law requires a psychiatrist to have control over a patient before he can be held liable” and second that “no duty should be placed on a psychiatrist in a voluntary, outpatient facility to involuntarily commit any patient.” Id. at 372-373, 727 S.E.2d at 173-174.

The trial court rejected Peterson’s arguments and the Court of Appeals affirmed. The Court of Appeals dismissed the “control” line of cases as inapplicable to malpractice actions; i.e., a medical practitioner, regardless of whether the patient is under the practitioner’s control, has a “long-recognized duty inherent in the doctor-patient relationship to exercise the applicable degree of care and skill in the treatment of [the] patient.” Id. at 375, 727 S.E.2d at 175. And if the applicable degree of care and skill in the treatment of the patient requires the patient’s involuntary commitment, then failing to commit the patient may amount to malpractice. The court stressed that it was “not creating[] a new ‘duty to commit.’ Rather, [it was] simply recognizing that, under some circumstances, the failure to commit may constitute a breach of the well-established duty of care physicians owe patients.” Id. at 378, 727 S.E.2d at 177.

In Everson v. Phoebe Sumter Medical Center, 341 Ga. App. 182, 798 S.E.2d 667 (2017) the Court of Appeals applied the medical negligence standard of care to a claim arising out of a patient’s suicide. 27 year-old Benjamin Everson went to Sumter Regional Hospital complaining that he was hallucinating and hearing voices. Dr. Brian Jordan, the emergency room physician, diagnosed Everson with obsessive compulsory
disorder and discharged him with an appointment to see a mental healthcare provider
two days later at a nearby facility. Instead, his father decided to have him evaluated at a
facility associated with Duke University. On the way to the appointment Everson leapt
from a moving car driven by his father and ran in front of another vehicle which struck
and killed him. Everson’s parents brought an action for medical malpractice against the
hospital and Dr. Jordan alleging that they failed to properly evaluate and treat Everson’s
condition when he went to the emergency room, misdiagnosed him and failed to
recognize that he needed a psychiatric evaluation. The trial court dismissed the action
as to the hospital, finding that the Plaintiff’s expert’s testimony regarding the attending
nurses failed to meet the requirements of O.C.G.A. § 24-7-702. As to Dr. Jordan, the
court found that it was a jury question as to whether Everson’s condition met the
requirements of the definition of emergency medical care so as to trigger the gross
negligence standard or whether the ordinary negligence standard of care would apply.
The Court further found that it was a jury question as to whether Everson’s suicide was a
reasonable foreseeable consequence of Dr. Jordan’s failure two days earlier to properly
diagnose and treat his psychosis.20

After Peterson and Everson both physicians and MHPs should be aware that
failing to involuntarily commit a patient, or failing to properly assess whether a patient
should be involuntarily committed, may constitute malpractice regardless of whether
the patient is under the practitioner’s control. But the practitioner must also be

20 On appeal, the Georgia Supreme Court reversed a part of Everson’s analysis of
On remand from the Supreme Court, the Court of Appeals held that the undisturbed
aspects of its decision still supported its holding that it was a jury question whether
Everson’s suicide was reasonably foreseeable. Jordan v. Everson, 345 Ga. App. 509, 511,
813 S.E.2d 600, 601 (2018).
cognizant that involuntarily committing patients may “expose doctors to an increased risk of liability in suits for false imprisonment.” Id. at 387, 727 S.E.2d at 181 (J. Andrews, dissenting).\textsuperscript{21}

Unresolved are several possible defenses to patient suicide claims. Among the least developed are defenses based on contributory or comparative negligence and lack of proximate causation.\textsuperscript{22} Georgia’s contributory negligence statute reduces a claimant’s recovery by the degree of his negligence, and bars a claimant from any recovery if the claimant bears fifty percent or more of the responsibility for the negligent act. O.C.G.A. § 51-11-7. The Georgia Court of Appeals has rejected the theory that suicide bars recovery as a matter of law as an act of contributory negligence where a special relationship exists between the patient and the defendant. Brandvain v. Ridgeview Inst., Inc., 188 Ga. App. 106, 119, 372 S.E.2d 265, 275 (1988) (holding that defenses of contributory or comparative negligence are matters for jury consideration and are not determinable as matter of law), aff’d, 259 Ga. 376, 382 S.E.2d 597 (1989); see also Peterson, 315 Ga. App. At 376, 727 S.E.2d at 176 (“proximate cause is undeniably a jury question and is always to be determined on the facts of each case upon mixed considerations of logic, common sense, justice, policy, and precedent” (citation omitted)). But see City of Richmond Hill v. Maia, 301 Ga. 257, 800 S.E.2d 573 (2017) (holding that absent a special relationship between the defendant and the decedent,  

\textsuperscript{21} The precedential value of Peterson is limited. Of the seven judges deciding the appeal, two joined the opinion, two concurred specially, and one concurred in the judgment only. Such a combination should be physical precedent only. Court of Appeals Rule 33(a). Nevertheless, the special concurrence mirrors the majority opinion, entirely agreeing with it in substance and only adding clarifications. While not binding precedent, Peterson is strong persuasive authority.

\textsuperscript{22} Lack of proximate cause is not truly a defense, as proximate causation is part of a plaintiff’s \textit{prima facie} case for negligence.
such as where the defendant owes a duty to prevent the decedent from harm, suicide is an intervening cause that absolves the defendant of liability). The Court in Brandvain also rejected the theory that suicide acts as an intervening cause, cutting off proximate causation. Id. at 116, 372 S.E.2d at 273 (suicide not an intervening cause if reasonably foreseeable to the defendant).

In Miranda v. Fulton DeKalb Hospital Authority, 284 Ga. App. 203, 664 S.E.2d 164 (2007), the Court of Appeals found that the alleged failure to properly monitor a suicidal patient was not the proximate cause of the patient’s suicide. The patient was placed in restraints with an order that he be monitored every 15 minutes. He managed to escape and committed suicide 15 hours later. Plaintiff’s expert witness testified that had the patient been continually monitored his escape would have been much more difficult. The Court concluded as a matter of law that this testimony failed to establish proximate cause.

Finally, Georgia law provides qualified statutory immunity to mental health professionals’ decisions to admit or discharge. O.C.G.A. § 37-3-4. This immunity can insulate these professionals if a patient is discharged and subsequently commits suicide, so long as the professional acted in good faith. See generally Poss v. Ga. Reg’l Hosp., 676 F. Supp. 258, 262 (S.D. Ga. 1987), aff’d sub nom., Poss v. Azar, 874 F.2d 820 (11th Cir. 1989). But that immunity is unavailable if the health professional “fail[ed] to meet the applicable standard of care in the provision of treatment to a patient.” O.C.G.A. § 37-3-4.

E. Sexual Relations With A Patient

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23 See also supra, Part II, Section A.
As a general rule, licensing board rules and ethical principles governing mental health professionals impose an absolute ban on sexual relations between mental health professionals and their current patients. In Georgia, such conduct can expose the professional to criminal prosecution and disciplinary sanctions by the appropriate licensing board,\(^{24}\) as well as substantial civil liability. These rules also generally prohibit a practitioner from entering into a professional relationship with a patient with whom the practitioner has had a sexual relationship.

Under Georgia law, a psychotherapist who engages in sexual relations with a patient is deemed to have committed the felony of sexual assault, consent of the victim is not a defense. O.C.G.A. § 16-6-5.1(e).\(^{25}\) The rationale for the Code section appears to be that a person under the care of a therapist is deemed to be in the “custody” of the therapist such that the patient cannot legally and knowingly consent to a sexual relationship with the therapist. Cf. Howard v. State, 272 Ga. 242, 243, 527 S.E.2d 194, 195 (2000) (“We observed that, to fulfill its role, the State can protect the public by enacting legislation which criminalizes various forms of sexual conduct, including sexual conduct which can be said to take place in private, between consenting adults: e.g., sexual contact with prisoners, the institutionalized, and the patients of psychotherapists (O.C.G.A. § 16-6-5.1); incest (O.C.G.A. § 16-6-22); and solicitation of sodomy (O.C.G.A. § 16-6-15).”). Apparently no Georgia appellate court has interpreted this Code section as it applies to mental health professionals, although there have been prosecutions of

\(^{24}\) Virtually all the licensing boards in Georgia governing mental health professionals now have disciplinary rules prohibiting sexual relations between the professional and a patient or client, as do the ethical codes of most national medical and mental health professional organizations.

\(^{25}\) An employee or volunteer at a mental health facility who engages in sexual contact with a patient is also guilty of sexual assault. O.C.G.A. § 16-6-5.1(d).

A mental health professional who ignores § 16-6-5.1 and the many ethical and professional rules proscribing sexual relationships with a patient likely faces a cause of action for medical malpractice, fraud, assault, battery, and intentional infliction of emotional distress. See, e.g., Hickey v. Askren, 198 Ga. App. 718, 403 S.E.2d 225 (1991) (decided on statute of limitation grounds). Furthermore, most insurers now expressly exclude such claims from coverage or limit the amount of coverage. Even absent such an exclusion, an insurer may take the position that such claims are not covered or are excluded by a general fraudulent or intentional acts exclusion. See Am. Home Assurance Co., 218 Ga. App. at 536, 462 S.E.2d at 444 (upholding provision in malpractice liability insurance policy limiting coverage to $25,000 in lawsuits involving sexual misconduct by the insured).

F. Child Abuse Reporting

The Georgia Child Abuse Reporting Act requires that healthcare professionals, including psychologists, nurses, professional counselors, social workers and marriage and family therapists, report suspected child abuse. Such a report is required notwithstanding “that the reasonable cause to believe such abuse has occurred or is occurring is based in whole or in part upon any communication to that person which is otherwise made privileged or confidential by law.” O.C.G.A. § 19-7-5(g). No private
right of action exists against healthcare professionals who fail to report. The Georgia courts have also held that healthcare professionals enjoy good faith immunity for incorrect reports of child abuse.

1. No Private Right Of Action For Failure To Report

O.C.G.A. § 19-17-5(f) provides that anyone who in good faith makes a report of child abuse is immune from civil or criminal liability. In addition, the Georgia courts have held that there is no private cause of action against a healthcare professional who fails to report suspected child abuse in violation of O.C.G.A. § 19-7-5(g). See Ceckman v. Travis, 202 Ga. App. 255, 414 S.E.2d 282 (1991) (O.C.G.A. § 19-7-5 does not create private right of action against a physician who failed to identify and/or report abuse); Vance v. TRC, 229 Ga. App. 608, 494 S.E.2d 714 (1997) (reaffirming Ceckman and holding that O.C.G.A. § 19-7-5(g) does not create a private right of action even where a physician failed to report possible sex abuse of a minor); Fulton-DeKalb Hosp. Auth. v. Reliance Trust Co., 270 Ga. App. 822, 608 S.E.2d 272 (2004) (O.C.G.A. § 19-7-5(g) does not create private right of action against a hospital for failing to identify and/or report evidence of suspected child abuse); see also, e.g., Anthony v. Am. Gen. Fin. Servs., 287 Ga. 448, 456, 697 S.E.2d 166, 172 (2010) (citing favorably to Ceckman and Vance for the proposition that “the public policy advanced by a penal statute, no matter how strong, cannot support the implication of a private civil cause of action that is not based on the actual provisions of the relevant statute” (emphasis in original)).

In 2006, the Georgia Court of Appeals reaffirmed that mental health providers have no duty to the victim to report suspected child abuse. McGarrah v. Posig, 280 Ga. App. 808, 635 S.E.2d 219 (2006). In McGarrah, a mother and guardian of a minor child brought an action against a licensed psychologist, who provided therapy and treatment
to the plaintiff’s son, and the psychologist’s practice, alleging that the psychologist 
breached a professional standard of care by her failure to detect and report alleged 
sexual abuse. The mother attempted to distinguish Cheehman, Vance, and Fulton-
DeKalb Hospital on the grounds that in those decisions the plaintiffs’ common-law 
claims failed, not because no cause of action at common law existed, but because the 
injury to the plaintiff was not the proximate result of the breach of any legal duty owed 
by the defendants. Id. at 809-810, 635 S.E.2d at 221. The Court disagreed, reaffirming 
that the legal duty to report child abuse is imposed by Georgia statute, which does not 
give rise to a private cause of action for damages.26 Id. at 810, 635 S.E.2d at 222.

2. Good Faith Immunity For Reports

The Georgia Child Abuse Reporting Act provides broad immunity for anyone who 
reports suspected child abuse. Under the Act, any person who participates in the 
making of a report of suspected child abuse is immune from civil or criminal liability 
that would otherwise be incurred, “provided such participation . . . is made in good 
faith.” O.C.G.A. § 19-7-5(f). In 2003, the Supreme Court of Georgia clarified the 
immunity provision of the Act in O’Heron v. Blaney, 276 Ga. 871, 583 S.E.2d 834 
(2003).

The Court in O’Heron held that the Act’s immunity provision allows immunity to 
attach in two ways, either by showing that “reasonable cause” exists, or by showing 
“good faith.” Id. at 873, 583 S.E.2d at 836. The Court explained that the Act requires a 
reporter who has reasonable cause to suspect child abuse to report to avoid facing 

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26 The Court acknowledged that, at least in Fulton-DeKalb Hosp., lack of proximate 
causation was an additional ground for denying the plaintiff’s recovery for damages 
resulting from failure to report suspected child abuse. McGarrah, 280 Ga. App. at 810, 
635 S.E.2d at 222.
criminal penalties. The trigger for the duty to report is a “reasonable cause to believe,” which requires an objective analysis. Id. at 872, 583 S.E.2d at 836. The relevant question, therefore, is “whether the information available at the time would lead a reasonable person in the position of the reporter to suspect abuse.” Id. at 873, 583 S.E.2d at 836. If an objective analysis supports the reporter’s conclusion that child abuse has occurred, then immunity attaches and there is no need to further examine the reporter’s good faith. Id.

If, on the other hand, the information would not lead a reasonable person to suspect child abuse under an objective standard, then the reporter may still enjoy immunity if she made the report in good faith. The Court described the Act’s good faith statute as a subjective one. It described the relevant question as “whether the reporter honestly believed she had a duty to report.” Id. A reporter acting in good faith enjoys immunity under the Act even if she is negligent or exercises bad judgment. Id. at 873-74, 583 S.E.2d at 836-37.
Christy D. Jordan, Esq.
Chief Operating Officer & General Counsel

Christy D. Jordan joined Southeast Georgia Health System in 2012 as Staff Attorney, served as the Director of Risk Management and Assistant General Counsel from 2012-2014 and was the Vice President, General Counsel/Government Relations for four years prior to her appointment as Chief Operating Officer & General Counsel. In that role, she provides leadership in the implementation of the Health System’s strategic initiatives, oversees the Legal, Compliance, Risk Management, Patient Experience and Business Planning & Development departments and provides operational leadership for the vice presidents of ancillary clinical services, general support services and the Camden Campus.

Prior to joining the Health System, Ms. Jordan was in private practice for eight years with nationally recognized health law practices, most recently with Arnall Golden Gregory, LLP. She has represented hospitals and health systems, hospice and long-term care providers, home health agencies, durable medical equipment suppliers, physician groups, private investors and other institutions that invest in or support the healthcare industry. Ms. Jordan is also licensed as a registered nurse, a background that gives her a unique perspective and understanding of health care legal and operational issues.

Ms. Jordan was named to Georgia Trend Magazine’s “Legal Elite” for Healthcare Law in 2017 and to the Becker’s Hospital Review 50 Healthcare Leaders Under 40 in 2016. She has served as President of the Georgia Academy of Healthcare Attorneys and is currently on the Executive Committee of the State Bar of Georgia’s Health Law Section. She is a member of the American College of Healthcare Executives, the American Health Lawyers Association and the Georgia State Bar. Ms. Jordan is also an Emeritus Board Member of Hospice of the Golden Isles and is a frequent speaker to community and legal groups on health care issues. Ms. Jordan received her undergraduate degree from the Medical College of Georgia and her Juris Doctorate from the University of Georgia School of Law.
Robert B. Remar is a partner with Rogers & Hardin LLP. In his more than 43 years of practice he has handled numerous complex, high profile litigation matters. He has tried scores of cases to juries in both state and federal courts. His practice focuses on complex commercial and business disputes, employment, administrative law, health care, class actions and civil rights/constitutional law. He also acts as an arbitrator and mediator. He is a Fellow of the American College of Trial Lawyers.

Mr. Remar is selected by Best Lawyers in America as the 2018 Atlanta “Lawyer of the Year” in Administrative/Regulatory law. He was also selected as the 2015 Atlanta “Lawyer of the Year” in Administrative/Regulatory law and, in 2014, as Atlanta “Lawyer of the Year” in First Amendment law.

For 12 years Mr. Remar was an Adjunct Professor teaching litigation at Georgia State University College of Law and for 13 years his practice included serving as the Hearing Officer for the Georgia Public Service Commission. He has been on the National Board of Directors of the American Civil Liberties Union for 31 years and currently serves as Vice-President, Treasurer, and Secretary.
TOP THREE ISSUES FACING LONG TERM CARE PROVIDERS IN 2019
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ATLANTA, GA
TOP THREE ISSUES FACING LONG TERM CARE PROVIDERS IN 2019

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THREE OF THE TOP ISSUES FACING LONG TERM CARE PROVIDERS IN 2019

BRITTANY H. CONE
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I. Introduction to Long Term Care

A. What is Long Term Care?

When a medical condition, trauma, or illness limits an individual's ability to perform basic personal health maintenance tasks (activities of daily living or ADLs), the individual may be in need of long term care ("LTC"). Unlike other forms of health care, the goal of LTC is not to cure any particular health condition, but rather to allow an individual to attain and maintain an appropriate level of functioning. As of 2014, about 1.4 million people received LTC services in certified nursing facilities. See https://www.cdc.gov/nchs/fastats/nursing-home-care.htm (accessed on February 22, 2019). As the United States population continues to age (baby boomers), the number of people in need of LTC services will continue to rise.

B. What is the cost of Long Term Care?

Staying in a LTC facility can be rather expensive. In fact, in 2018, the average annual cost of a semi-private room in a Georgia nursing home was approximately $76,000. See https://www.genworth.com/about-us/industry-expertise/cost-of-care.html (accessed on February 22, 2019). The total cost of LTC spending exceeds $339 Billion, with Medicare and Medicaid accounting for over $242 Billion. See https://fas.org/sgp/crs/misc/R43483.pdf (accessed on February 22, 2019). Medicaid is the primary payment source for LTC, totaling approximately forty-three percent (43%) of all LTC spending. Id. Medicare, on the other hand, does not pay for usual LTC services, but rather provides reimbursement for short-term skilled nursing services.

C. What laws govern Long Term Care Providers?

The laws governing LTC providers come from several different sources. First, the Federal Omnibus Budget Reconciliation Act ("OBRA") Regulations, found at 42 C.F.R. § 483 et seq., provide the "Conditions of Participation" for skilled nursing facilities that receive federal and state funding. Second, each state has its own rules and regulations governing nursing facilities. Georgia's regulations are found at Ga. Comp. R. & Regs. § 111-8-50 et seq. and Ga. Comp. R. & Regs. § 111-8-56 et seq. Third, the Medicare and Medicaid manuals provide additional guidance for LTC providers.
II. Payment for Services Rendered

A. Medicare Appeals and Medicaid Backlog

Currently, LTC providers in Georgia are enduring severe wait times related to its two primary payment sources, Medicare and Medicaid. Both Levels 3 and 4 of the Medicare appeals process are suffering from a severe backlog. In order to address these severe processing delays, the U.S. Department of Health and Human Services (“HHS”) issued a final rule to improve the Medicare appeals process. See [https://www.hhs.gov/sites/default/files/medicare-appeals-final-rule-fact-sheet-jan2017.pdf](https://www.hhs.gov/sites/default/files/medicare-appeals-final-rule-fact-sheet-jan2017.pdf) (accessed February 22, 2018). While HHS states it will not be able to eliminate the entire backlog by December 31, 2020, as ordered, it may eliminate the backlog completely by 2022. See [https://www.modernhealthcare.com/article/20180806/NEWS/180809936](https://www.modernhealthcare.com/article/20180806/NEWS/180809936) (accessed February 22, 2019).

Georgia LTC providers are also enduring significant delays in receiving Medicaid payments from the state for services rendered to eligible patients. Providers are still suffering from the overhaul of the Georgia Medicaid system vis-à-vis the transfer to the GATEWAY system, including processing time outside of the 45-day timeframe required by the Georgia Medicaid rules. In addition, LTC providers across the state have reported difficulties reaching Medicaid caseworkers to confirm receipt of applications or determine the status of already pending applications. Once an application is approved, there have also been system errors preventing providers from being properly paid for the care and services provided. These delays have placed some LTC providers in temporary financial straits and at odds with how to handle the accruing balances owed by Medicaid-pending patients.

B. Patient Driven Payment Model (“PDPM”)

The Patient-Driven Payment Model is intended to replace the current RUG-IV system in calculating reimbursement. Therapy minutes as a basis for payment will be no more, and instead payment will be calculated based on resident classifications and anticipated resource needs. PDPM will go into place effective October 1, 2019.

PDPM will require provider to manage the delivery of services to provide the right level of care for each resident. Over delivery of services will not result in additional payment beyond the reimbursement level for the resident classification, whereas under-delivery will lead to poor patient outcomes and potential Medicare audits and recoupments.

Patients will be assigned to a case-mix group (physical, occupational or speech therapy, Nursing, and Non-Therapy Ancillary Services (“NTAS”).

C. Medicare Advantage Plans

Up to 33% of the Medicare-eligible population participates in a Medicare Advantage plan. Medicare Advantage has lower SNF utilization, SNF average lengths of stay, and reimbursement than traditional Medicare Fee for Service. These plans may contract directly
with the facilities, have their own payment rules, and require certain dispute resolution processes.

III. Social Media

With the continued increase in the use of social media, LTC providers must be prepared to respond to day-to-day situations they face, knowing their action, or inaction, will be scrutinized by the court of public opinion.

For example, following Hurricane Irma, Hollywood Hills Nursing Home became the subject of national attention when 14 residents died over the course of 62 hours. Twelve of those deaths were ruled homicides as the heat soared to 99 degrees Fahrenheit. Videos posted online show residents suffering in the heat and sparked outrage across the country.

Still other videos posted online, many through the use of granny cams, show abuse, neglect, or other poor conditions. The videos are posted by disgruntled families, and even staff. They have been used to drive high verdicts in civil actions. Facebook pages, and online reviews, include both positive and negative reviews that can be found in a simple search of the facility name.

Long term care facilities must be prepared to respond not only to the crisis, but also to the potential backlash vis-à-vis social media. This includes communication with staff and families, as well as expectation management. Facilities should have policies and procedures in place to address the use of social media to include guidelines not only for staff but also residents and their families based on HIPAA guidelines. They must also prepared to respond to any public disclosures.

IV. Reporting Standards

LTC providers are required to report allegations of abuse or neglect within certain parameters set by the state—24 hours for most; not later than 2 hours after the allegation is made if the events that cause the allegation involve abuse or result in serious bodily injury. Additional guidelines apply if there is a suspicion of a crime or if the allegation involves sexual misconduct.

While there are stiff penalties for failing to follow the reporting guidelines, an increased focus on abuse, neglect, and injuries of unknown origin have pushed providers to, in many instances, over report. Over reporting can have serious repercussions not only for the individuals involved, but for the facility itself. The reports can be used in litigation, and the materials sent to the state, in many instances, are not privileged. Additionally, if the report forms the basis of a state survey, the survey results are public.

LTC facilities should be mindful certainly not to under-report. However, they should also understand what must be reported, as well as what is not reportable, in order to limit the negative repercussions associated with reporting.
V. Conclusion

LTC providers face numerous obstacles on a day-to-day basis in their delivery of care to residents. Attorneys representing LTC providers must understand the obligations placed on these providers from both a civil and regulatory standpoint.
OVERVIEW

Brittany H. Cone, CHC, is a Partner in the firm’s Atlanta office. She focuses her practice on a wide range of regulatory, administrative and litigation matters in health care.

Certified in Health Care Compliance by the Health Care Compliance Association, Brittany works with providers on the full spectrum of issues they face including Medicare, Medicaid, regulatory compliance, administrative hearings and appeals.

Brittany received a Juris Doctorate from Georgia State University College of Law, where she was a member of the Law Review and served as associate symposium editor and associate editor for student notes. She also served as an extern for the Honorable A. Harris Adams of the Georgia Court of Appeals. Brittany completed a Bachelor of Arts in psychology with a minor in Spanish at Berry College, and she studied at the Center for Cross Cultural Studies in Seville, Spain.

PRACTICE AREAS

AGING SERVICES

Brittany has worked with hospitals, skilled nursing facilities, personal care homes, assisted living facilities, home health and physician practices, especially focusing on regulatory and operational issues.

HEALTH CARE

Brittany has advised healthcare providers on compliance with Federal, State, and local laws and regulations. She has counseled clients in managing the regulatory aspects of health care transactions, especially change of ownership licensing and operation issues and Medicare and Medicaid reimbursement issues. Additionally, she assists clients with complying with the Patient Care and Affordable Care Act, including the development of an effective compliance program.

Brittany has also assisted clients with self reporting requirements, internal investigations, including those in response to OIG investigations, the False Claims Act, Stark and Anti-Kickback. Ms. Cone has spent a significant portion of her practice assisting providers with the Health Insurance Portability and Accountability Act (HIPAA), including developing HIPAA policies and procedures and breach response.

PROFESSIONAL NEGLIGENCE / MEDICAL MALPRACTICE

Ms. Cone has assisted professionals in malpractice actions in all phases of litigation.
BRITTANY H. CONE | continued

EDUCATION

• Georgia State University College of Law, J.D.
• Berry College, Bachelor of Arts in Psychology, Spanish Minor, cum laude
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PRESENTATIONS / PUBLICATIONS

• “Rising to the Top: It’s the Little Things- Controlling the Narrative: Crisis Communication and Expectation Management,” Georgia Health Care Association Bi-annual Convention, January 2018.
• “Disclosures: How Much is Too Much,” Georgia Health Care Association Bi-annual Convention, June 2016.
• “Surrogate Decision Makers, Privacy and Current Trends” Georgia Health Care Association Bi-annual Convention January 22, 2016
• “Preparing for and Navigating the IDR and IIDR Process,” Georgia Health Care Association, March 20, 2015
• “Making a Molehill out of a Mountain” - Legal update on SNF 5 Star Rating System and the IMPACT Act, Georgia Health Care Association Bi-annual Convention, January 23, 2015
• Update on OIG focus on culture of compliance, creating effective communication systems, Georgia Health Care Association Bi-annual Convention, January 24, 2014
• “Managing the Unmanageable: How effective expectation management can be used in all levels of operations”, Georgia Health Care Association Bi-annual convention, June 2013
• Skilled Nursing Facility Compliance Bootcamp- Preparing Your Team, Georgia Health Care Association, November, 2012
• “5 Essential Areas for your Compliance Program”, Georgia Health Care Association, June, 2012
• “Skilled Nursing Facility Compliance Bootcamp- The Nuts and Bolts”, Georgia Health Care Association, May, 2012
• “Skilled Nursing Facility Compliance Bootcamp- Gathering the Tools You Need”, Georgia Health Care Association, December, 2011
• “Residents Rights Boot Camp: Life After the Affordable Care Act,” Georgia Health Care Association, August 26, 2010, Macon, GA
Appendix
ICLE BOARD

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Term Expires</th>
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</thead>
<tbody>
<tr>
<td>Ms. Carol V. Clark</td>
<td>Member</td>
<td>2019</td>
</tr>
<tr>
<td>Mr. Harold T. Daniel, Jr.</td>
<td>Member</td>
<td>2019</td>
</tr>
<tr>
<td>Ms. Laverne Lewis Gaskins</td>
<td>Member</td>
<td>2021</td>
</tr>
<tr>
<td>Ms. Allegra J. Lawrence</td>
<td>Member</td>
<td>2019</td>
</tr>
<tr>
<td>Mr. C. James McCallar, Jr.</td>
<td>Member</td>
<td>2021</td>
</tr>
<tr>
<td>Mrs. Jennifer Campbell Mock</td>
<td>Member</td>
<td>2020</td>
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<tr>
<td>Mr. Brian DeVoe Rogers</td>
<td>Member</td>
<td>2019</td>
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<tr>
<td>Mr. Kenneth L. Shigley</td>
<td>Member</td>
<td>2020</td>
</tr>
<tr>
<td>Mr. A. James Elliott</td>
<td>Emory University</td>
<td>2019</td>
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<tr>
<td>Mr. Buddy M. Mears</td>
<td>John Marshall</td>
<td>2019</td>
</tr>
<tr>
<td>Daisy Hurst Floyd</td>
<td>Mercer University</td>
<td>2019</td>
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<tr>
<td>Mr. Cassady Vaughn Brewer</td>
<td>Georgia State University</td>
<td>2019</td>
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<tr>
<td>Ms. Carol Ellis Morgan</td>
<td>University of Georgia</td>
<td>2019</td>
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<tr>
<td>Hon. John J. Ellington</td>
<td>Liaison</td>
<td>2019</td>
</tr>
<tr>
<td>Mr. Jeffrey Reese Davis</td>
<td>Staff Liaison</td>
<td>2019</td>
</tr>
<tr>
<td>Ms. Tangela Sarita King</td>
<td>Staff Liaison</td>
<td>2019</td>
</tr>
</tbody>
</table>
GEORGIA MANDATORY CLE FACT SHEET

Every “active” attorney in Georgia must attend 12 “approved” CLE hours of instruction annually, with one of the CLE hours being in the area of legal ethics and one of the CLE hours being in the area of professionalism. Furthermore, any attorney who appears as sole or lead counsel in the Superior or State Courts of Georgia in any contested civil case or in the trial of a criminal case in 1990 or in any subsequent calendar year, must complete for such year a minimum of three hours of continuing legal education activity in the area of trial practice. These trial practice hours are included in, and not in addition to, the 12 hour requirement. ICLE is an “accredited” provider of “approved” CLE instruction.

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