Illinois Health Planning Reform: Competition, Certificates of Need and Charity Care

David F. Buysse
Office of the Attorney General

June 9, 2008

Good morning. My name is David Buysse and I'm a senior assistant attorney general in the office of Illinois Attorney General Lisa Madigan. As a member of the Special Litigation Bureau, I have participated in the Attorney General's ongoing investigation of Illinois not-for-profit hospitals since the fall of 2003.

The Illinois Health Facilities Planning Act (20 ILCS 3960/1, *et seq.*) was first enacted in 1974 pursuant to the mandate of the National Health Planning and Resources Development Act of 1974. The purposes of the Act are set forth in Section 2:

> The purpose of this Act is to establish a procedure designed to reverse the trends of increasing costs of health care resulting from unnecessary construction or modification of health care facilities. Such procedure shall represent an attempt by the State of Illinois to improve the financial ability of the public to obtain necessary health services, and to establish an orderly and comprehensive health care delivery system which will guarantee the availability of quality health care to the general public.

The 2007 Lewin Group Report – *An Evaluation of Illinois' Certificate of Need Program* – correctly summarized the continuing goals of the Act to be containing costs and improving access and quality for the general public. The effectiveness

of the CON process in achieving these goals has been a subject of debate for some time. Several diverse voices are heard in this debate. For example:

The Federal Trade Commission and the Department of Justice have primary enforcement responsibilities for the Federal antitrust laws. So far in 2008, the Federal Trade Commission has submitted rather similar written statements to committees of both the Alaska House of Representatives and the Florida Senate considering reform of each state's CON laws. The Commission argues in each statement that a CON law can be a barrier to market entry operating to the detriment of health care competition and health care consumers. The Commission's position is based largely on the joint report prepared by the FTC with the Department of Justice in July, 2004 entitled *Improving Health Care: A Dose of Competition.* In the Report, the Agencies asserted that, "...on balance, CON programs are not successful in containing health care costs, and that they pose serious anticompetitive risks that usually outweigh their purported economic benefits."

Conversely, in 2005, the American Health Planning Association published a critique of the FTC/DOJ study *Improving Health Care.* In addition to questioning the reliability of studies relied upon by the FTC and its view that health care is simply a commodity like any other, AHPA argued for the value of a CON process as a market balancing tool:

> In a necessarily imperfect, and an increasingly inequitable, health care system, community-based planning and CON regulation are flexible tools that, when used intelligently and objectively, help protect the critical health care infrastructure that is required to meet both expected and unanticipated public need. Market forces are invaluable in balancing the cost, supply, access, and quality of most goods and services. Market fluctuations and vagaries are acceptable for most commodities, but are problematic for essential social goods and services, especially health care.

Last month, the Illinois Hospital Association presented the view that the primary purpose of the CON process should be "to prevent unnecessary duplication of health care facilities and services in order to preserve access to safety net services across Illinois." The Association also acknowledged that the evidence is weak that CON has had an impact on cost containment and suggested that a myriad of factors contribute to health care cost increases. Consequently, the Association believes the role of the Planning Board in cost containment should be secondary.

Whatever theoretical approach one takes to the role of CON in health planning – the free market skepticism of the FTC, the relative enthusiasm of AHPA, or the sort of middle road advocated by the IHA – an important *legal* effect of CON should be clearly recognized. When new firms seek to enter a market, existing firms may attempt to deter or prevent new competition. Such conduct is certainly not unique to health care markets. In many circumstances, such conduct may violate the antitrust laws. Certain types of anticompetitive

conduct may nevertheless be shielded from antitrust scrutiny. The examples most pertinent to consideration of CON regulation include:

- **The *Noerr-Pennington* doctrine** – defined in two U.S. Supreme Court cases in the 1960's – which serves to immunize conduct which involves petitioning the government, even when such petitioning is done "to restrain competition or gain advantage over competitors," and
- **The "state action" doctrine** - which shields many of a state's own activities when a state government is acting in its sovereign, legislative capacity, and also immunizes from antitrust scrutiny the actions of other entities and individuals if they are acting in furtherance of a clearly articulated state policy and are actively supervised by the state.

The FTC statement to the Florida Senate suggests that, "(i)n the context of health care competition, the combination of these two doctrines can offer antitrust immunity to providers that wish to lobby state officials to impede the entry of potential competitors, by denying or delaying the CONs required for operation." The protection afforded under these legal doctrines is arguably what allows the use of the CON process "to prevent unnecessary duplication of health care facilities and services" which might otherwise occur in a marketplace without such a process inhibiting entry.

Such protection is obviously an important tool for policy makers in Illinois. The Attorney General believes that the CON process and protection offered to health facilities should continue to further the original purposes of the Illinois Health Facilities Planning Act. Since access to "necessary health services" remains an unfulfilled goal – certainly to a greater degree than the "prevention of unnecessary duplication of health care facilities and services" – reform of health planning and the CON process in Illinois should mandate specific criteria for classes of health facilities participating in the CON process to increase accessibility to necessary health services to those Illinois residents whose access to such services remains dangerously deficient.

Contrary to the suggestion that efforts to increase accessibility constitute agendas unrelated to health planning, other states continue to recognize the clear connection between the CON process and increased accessibility for indigent residents. For example,

- In **South Carolina**, the regulations for the certificate of need process requires an Indigent Care Plan documenting a facility's provision of indigent care for three years before application and the anticipated provision in the future (South Carolina Department of Health and Environmental Control, Regulation 61-15)

- In **New Jersey**, specific criteria for review of CON applications include "(h)ow and to what extent the applicant will provide services to the medically indigent, Medicare recipients, Medicaid recipients and members of medically underserved groups" and "(t)he amount of charity care, both free and below cost service, that will be provided by the applicant." (NJAC Title 8, Chapter 33).

- On May 19. 2008, **Florida** Governor Crist signed legislation streamlining the state's certificate-of-need process. While the bill includes a "loser pays" provision to cover a hospital's legal fees if there is an unsuccessful appeal after a CON has been granted by the state, the review criteria for general hospitals concerning an applicant's past and proposed provision of health care services to Medicaid patients and the medically indigent survived efforts at streamlining. (SB 2326)

Virginia

The witness from the American Health Planning Association testifying before the Task Force previously alluded to the experience of Virginia, noting that it first repealed its original CON process and subsequently enacted another. In the Commonwealth of Virginia, the Commissioner of Health makes final decisions on CON after receiving recommendations from the Department of Health and from one of five regional planning agencies. The Commissioner may condition the approval of a certificate upon the agreement of the applicant to

> (a) provide a level of care at reduced rate to indigents or accept patients requiring specialized care; or
>
> (b) upon the agreement of the applicant to facilitate the development and operation of primary medical services in designated medically underserved areas for the applicant's service area.

Virginia charity care requirement amounts are tied to the average regional charity care percentage of acute care hospitals, and may change from year to year. Ambulatory surgery centers were actually the first type of facilities to

which these requirements were applied. The requirement now applies to other types of facilities and equipments.

Facilities in Virginia are required to keep and submit copies of a charity care log that includes at a minimum the date of service, patient's age, ZIP codes, city and county, procedure or service type, total charges for the services provided, and any amount ultimately charged to the patients. In addition, any associated physician or medical service billed to the patient must also be tracked. Facilities willfully neglecting to comply are subject to a civil penalty up to $100 per violation per day.

In addition to directly providing medical services at reduced or no cost to the medically indigent, facilities can meet their charity care requirement by "facilitating the development and operation of primary medical services to indigent persons." Examples of what this could entail include providing transportation, establishing a new service such as a new free clinic, or making a "donation" to a recognized facility whose mission is to care for the medically indigent. The condition can be satisfied by:

- Provision of indigent care by the CON conditioned service at a rate equal to or greater than that established on the CON
- Documented new efforts or initiative to provide primary care to indigents
- Direct payments to any organization established under a memorandum of understanding with the Virginia Department of Health as authorized to receive and distribution contributions satisfying CON condition,

including but not limited to the Virginia Association of Free Clinics and the Virginia Primary Care Association.

The charity care conditions remain in effect over the life of the service authorized by the CON and through successive generations when equipment is replaced or upgraded. Applications from facilities refusing to comply with the charity care condition are recommended for denial. Compliance can be enhanced by public disclosure via publication of non-compliant facilities. Facilities which have been deemed non-compliant may be denied a CON for future proposed projects.

According to the Central Virginia Health Planning Agency, the charity care requirements and efforts around enforcement in Virginia have resulted in:

- Increased charity care provided by hospitals and other service providers and reduced bad debts
- Enhanced outreach by regulated facilities to safety net providers and their patients, and greater collaboration
- Increased efforts to develop services needed by low income persons
- Better tracking of charity care provided

Illinois

Attorney General Madigan strongly believes that the original goals of the Act - containing costs and improving access and quality for the general public – provide the foundation for the directives for the Task Force which the General Assembly enumerated in Section 15.5. Of particular relevance to accessibility to

"necessary health services" is the directive in Section 15.5 (c)(6) regarding the "(i)mplementation of policies and procedures necessary for the Illinois Health Facilities Planning Board to give special consideration to the impact of the projects it reviews on access to 'safety net' services." In addressing the other directives from the General Assembly in Section 15.5 intended to streamline and rationalize the operation of health planning in Illinois, the importance of increasing accessibility and protecting the health care safety should not be neglected.

Policies regarding the provision of health care to low income persons should be included in the report to be prepared by the Task Force and any legislation drafted in accordance with the recommendations of the report. The Task Force should consider policies including:

- Specific minimum requirements regarding the provision of charity care by the classes of health facilities under the purview of the Act.
- Specific requirements regarding the provision of care to Medicaid recipients by the classes of health facilities under the purview of the Act.
- Specific criteria for CON applications regarding the provision of charity care and care to Medicaid recipients.
- Specific annual reporting requirements concerning the provision of such care.
- Flexibility in the manner in which such requirements and criteria can be satisfied.

Thank you for your kind attention. I'll try to answer any questions you may have.