Don't Tread on Me

by John Steen

At the beginning of this year, the American Health Planning Association (AHPA) posted a critique of the Federal Trade Commission/Department of Justice (FTC/DOJ) policy entitled, The Federal Trade Commission & Certificate of Need Regulation, An AHPA Critique, on its website. To access it, go to: http://www.ahpanet.org/Images/AHPAcritiqueFTC.pdf. See especially pp.12ff, also published in the 4th Quarter, 2004 issue of Health Planning TODAY, pp. 6-8.

The State of Vermont offers an illustration of what can be at stake when the federal government tries to impose its doctrines on state prerogatives in planning and regulation, including Certificate of Need (CON). Since November, Vermont's 12 health agencies that provide in-home care for the elderly and infirm have been under scrutiny by the DOJ for possible violation of anti-trust laws and conspiring to keep other firms from providing similar care.The wide-ranging federal probe is part of the DOJ's effort to examine CON laws and if they are being used as a way to curb competition in health care.

Background: Home Health Care in Vermont

The strength and resiliency of Vermont's home health system have been well-demonstrated in recent years. Vermont's community-based, non-profit home health agencies have been highly successful in assuring that all Vermonters have access to comprehensive, high quality, low cost, medically necessary home health services and hospice services, regardless of ability to pay or location of their residence. Vermont is the only state where no agency closed as a result of the federal changes to Medicare reimbursement known as the Interim Payment System (IPS), changes that shut-down over 3000 agencies in the other 49 states.

Federal data show that Vermont's 12 non-profit agencies treat more patients per capita than any other state, and Vermont has the lowest cost-per-visit for home health care of all fifty states. Nearly 80 percent of the state's home health care revenue is in the form of Medicaid and Medicare reimbursements, with only 6-10 percent covered by private insurance. In 2002, Vermont served 108 per 1,000 Medicare eligible people compared to the national average of 61 per 1,000 and the New England average of 81 per 1,000 (Source: Vermont Assembly of Home Health Agencies [VAHHA]) It also had the lowest cost per episode (60 days of care) of the 50 states in 2002, according to the National Association for Home Care (Washington, DC).

The state's 1999 CON guidelines, backed up by the State Health Plan, support the retention and protection of this system from competition by new for-profit and not-for-profit agencies. Vermont's CON law contains a provision that any home health service other than those non-profit agencies in existence at the time of the law – the home health agencies named in the DOJ probe – would need to undergo a CON review. Several private, Vermont-based nursing and home health providers have attempted to gain approval from state regulators, but the state has refused to grant them one on the basis of unnecessary service duplication. One firm, Professional Nurses Service (PNS), has just been granted such approval, the first in 25 years. However, the existing 12 non-competing visiting nurse agencies can thwart PNS' efforts if they can show by July 9 that they can provide enough services to ensure that no one is left on a waiting list in

Vermont.

DOJ Prompts Legislative Initiative

At the end of May, the Vermont legislature enacted new legislation in response to the DOJ's intervention. The legislation establishes an explicit and clearly articulated state policy permitting and regulating the existing cooperation and coordination currently investigated by the Justice Department. It codifies the existing system of home health agencies in Vermont as reflected in Vermont's State Health Plans of 1980-1985, 1985-1990 and 1990-1993, Health Resources Management Plans of 1993-1996 and 1996-1999, and the CON Guidelines that have been in effect since 1999. The state policy enunciated in these plans favors the delivery of home health services by a community-based and supported non-profit home health agency system, and expressly favors collaboration among these agencies over a competitive, market-driven system. It expressly designates geographical areas to be served by each of the existing non-profit home health agencies. It makes a clear statement of state policy that supports the existing non-competitive community-based non-profit model for delivery of home health services, and reiterates the responsibility of the existing home health agencies to meet the needs of their respective communities. It continues the present standards for approving new competing home health agencies. It continues state collection of data on cost, access, and quality.

The legislation was approved by the House by a unanimous 132-0 vote, and by the Senate on a 24-2 vote. It enables the existing 12 visiting nurse agencies to serve patients within the state's existing service territories (largely county boundaries). That practice, among others, is precisely what has been under investigation since last November by the DOJ for possible violations of federal anti-trust laws.

"We don't want the federal government dictating how we deliver care in this state more than they already do. This bill is intended to protect a Vermont solution to providing care for the home bound that works," said State Senator Jim Leddy, the Chair of the Senate Health and Welfare Committee. Senator Leddy said the current system that fosters cooperation helps keep costs down. He said the investigation interferes with state's efforts to efficiently and effectively deliver health care. The legislation started in Leddy's committee and received a 6-0 vote there. The House Health Committee also voted unanimously for the legislation as did both the House and Senate Appropriations committees. Republican Gov. James Douglas indicated he would sign the bill into law.

What Is at Stake?

Vermont's community values are manifest throughout the state, and are evident in its forty-year history of state planning in long term care. That was well described in a statement made by VAHHA to the Governor's Bipartisan Commission on Health Care Availability & Affordability (appointed by Gov. Howard Dean in January, 2001):

The current market structure, although not a competitive one, does achieve the desired goal of competition: universal access, low cost, and high service quality. Proponents of the totally open market argue that competition would drive costs down, give consumers more choice, and assure

greater access to home care services. Data suggests otherwise.

Repeatedly during the past decade, we have invited these proponents of competition to identify one single state that has competition which they believe has a better home health system than Vermont. So far not a single state has risen to this "Pepsi Challenge." In fact, in the wake of critical stressors in the Medicare funding of home health during recent years, the resiliency and strength of Vermont's system has been amply demonstrated: there has not been a single closing in Vermont, patients with "high cost" needs have not been "dumped;" patients who have fallen through the cracks and become ineligible for Medicare funding have continued to be served.

With the current nonprofit system, Vermonters are much more likely to get needed home health services than other Americans. Health care, including home health services, is not a commodity, nor is it available to consumers in the same competitive market structures as other services. Competition simply for the sake of competition is not a valid goal in health care. What is important is assuring that all Vermonters, regardless of income and place of residence, have access to comprehensive, high quality, reasonably priced care. Vermonters have that now.

State Action Immunity vs. Competition

The legal issue here is whether the state is protected under the doctrine of "state action immunity," a protection arising from a United States Supreme Court decision affirming the authority of states to approve and regulate activities within their borders. It applies, for example, to state health planning policies to foster collaborative arrangements in order to create rural provider networks where markets cannot support more than one or two and must be stabilized to permit efficient delivery of healthcare. Here CON meets the legal tests for "clearly articulated and affirmatively expressed" state policies and "active state supervision" through state regulation. However, Vermont has not "clearly articulated and affirmatively expressed" its home health care policies until now, so the question is whether such immunity applies retroactively. That leaves open a 'back-door' through which the federal doctrines may challenge state authority.

Ironically, a study prepared for the federal Department of Health and Human Services' Centers for Medicare and Medicaid Services documents what Vermont's state health planning for community-based home health care has achieved. Entitled Promising Practices in Long Term Care Systems Reform: Vermont's Home and Community Based Service System, by Diane Justice of Medstat, September 8, 2003It is accessible at http://www.cms.hhs.gov/promisingpractices/vthcbss.pdf.