UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA
BLUEFIELD DIVISION

UNITED STATES OF AMERICA,
Plaintiff,

v. Civil Action No. 1:05-0234

BLUEFIELD REGIONAL MEDICAL CENTER, INC., and PRINCETON COMMUNITY HOSPITAL ASSOCIATION, INC.,
Defendants.

RESPONSE TO COMPETITIVE IMPACT STATEMENT ON BEHALF OF THE WEST VIRGINIA HEALTH CARE AUTHORITY

The West Virginia Health Care Authority (hereinafter "Authority") files this response to the Competitive Impact Statement published on April 7, 2005. The purpose of this response is to set forth the Authority's analysis of the state action doctrine and to clarify the statutory powers conferred upon the Authority by the West Virginia Legislature.

I. STATEMENT OF FACTS

A. History of Bluefield Regional Medical Center and Princeton Community Hospital

Bluefield Regional Medical Center (hereinafter "BRMC") owns and operates a 265 bed acute care not-for-profit hospital in Bluefield, West Virginia. Princeton Community Hospital (hereinafter "PCH") owns and operates a 211 bed acute care not-for-profit hospital in Princeton, West Virginia. In addition to the Princeton facility, PCH

also owns and operates St. Luke's Hospital, LLC, a 79 bed acute care hospital in Bluefield, West Virginia.

BRMC and PCH are located in close proximity to one another in Mercer County, Southern West Virginia. Mercer County ranks 15 out of 55 counties for the percentage of non-elderly adults without health insurance in the State of West Virginia.[1] Thus, a significant portion of the population of this county is rural and uninsured.

B. Overview of the West Virginia Health Care Authority, its cost based rate review system and the Certificate of Need program

By way of background, the Health Care Cost Review Authority (hereinafter "HCCRA") was created by the Legislature in 1983, as an autonomous agency within state government. W.Va. Code § 16-29B-5. The Authority, then known as HCCRA, is charged with the responsibility for collecting information on health care costs, developing a system of cost control, and ensuring accessibility to appropriate acute care beds. W.Va. Code §§ 16-29B-1, *et seq.*

This same legislation expanded the HCCRA's responsibilities to include the administration of two previously enacted cost containment programs: (1) the Certificate of Need (hereinafter "CON") program, which is codified at W.Va. Code §§ 16-2D-1, *et seq.*; and (2) the Health Care Financial Disclosure Act, which is codified at W.Va. Code §§ 16-5F-1, *et seq.* In 1997, the Legislature enacted a statute renaming the HCCRA as the West Virginia Health Care Authority. W.Va. Code § 16-29B-2.

[1] Health Insurance in West Virginia: The Non-elderly Adult Report, July 2002 and reprinted May 2003 available at www.wvhealthpolicy.org/reports_2002.htm

The Authority's purpose is "to protect the health and well-being of the citizens of this state by guarding against unreasonable loss of economic resources as well as to ensure the continuation of appropriate access to cost-effective high quality health care services." W.Va. Code § 16-29B-1. This statute created a three member Board vested with the power to "approve or disapprove hospital rates...." W.Va. Code §§ 16-29B-5 & 19.

The Authority establishes hospital rates for a group of payors termed "nongovernmental payors" or "other payors." This group includes public and private insurers, persons who pay for their own hospital services and all other third party payors who are not government-related. W.Va. Code §§ 16-29B-1, *et seq.*; Hospital Cost Based Rate Review System, 65 C.S.R. §§ 5-1, *et seq.*

The Authority is also statutorily responsible for establishing the nongovernmental average charge per discharge for inpatient and outpatient services for acute care hospitals in the state. Accordingly, once a year, hospitals may file a rate application with the Authority seeking a rate increase pursuant to W.Va. Code § 16-29B-21. Ultimately, the Authority has the right to: (1) approve a rate request, (2) modify a rate request, or (3) deny a rate request. W.Va. Code § 16-29B-19.

In evaluating rate applications, the Authority utilizes a hospital's rate application as the primary source of information in setting its rates. The Authority also utilizes other documents on file with the Authority as additional sources of data, such as audited financial statements, Uniform Reporting System Financial Reports, Medicare Cost Reports, the hospital's trial balance and the Uniform Billing (hereinafter "UB") UB-92

discharge bills. The Authority then compares the rate application to the audited financial statements, the Uniform Financial Report and the Medicare Cost Report in order to determine whether the information in the rate application is consistent, in all material aspects, with the other filings. The UB-92 information is used to compare discharges and case mix indices. The case mix for each hospital is determined from diagnostic related groups (hereinafter "DRG") weights in effect during the hospital's fiscal year.

The Authority establishes several limits during the rate setting process and a hospital is expected to monitor each of these limits to ensure that it is in compliance with the Authority's established rates. W.Va. C.S.R. § 65-5-10.2. If a hospital exceeds its approved rates, then it has an overage. This overage may be justified through case mix, outliers, new service or other events which could not have reasonably been foreseen. W.Va. C.S.R. §§ 65-5-10.3 - 10.3.4. If any portion of the overage is not justified, then the hospital has an unjustified overage and is subject to penalties in subsequent years.

With respect to the CON program, the Authority's Board has been empowered by the Legislature to enact legislative rules, to develop the State Health Plan and to consider CON applications. W.Va. Code §§ 16-2D-3(b)(5); 16-2D-5. The law requires that a hospital obtain a CON prior to developing cardiac surgery or radiation therapy services.

With respect to the State Health Plan Cardiac Surgery Standards, the Authority has exhibited a preference for joint applicants seeking to provide cardiac surgery

services. The Authority encouraged parties to work together to ensure that services were not duplicated in the various geographic areas in order to ensure the development of a quality open heart program. Several studies have shown a direct correlation between high volume programs and success rates. Therefore, the Authority determined that joint applications would produce greater volumes and therefore provide greater quality of service.

C. CON applications filed by BRMC for the development of cardiac surgery services and PCH for the development of a comprehensive cancer center

In 1999, BRMC submitted an application to offer cardiac surgery services. While a need appeared to exist in the area, the Authority denied this request because BRMC was not able to show that it would be able to attract a sufficient number of patients without working with other area hospitals, namely PCH. On January 23, 2003, BRMC, Charleston Area Medical Center, and PCH submitted a joint application for a CON to establish cardiac surgery services to be located at BRMC. This application was initially contested by Richard Lindsay, M.D., the West Virginia Consumer Advocate (hereinafter "WVCA"), and the West Virginia Public Employees Insurance Agency (hereinafter "WVPEIA"). WVCA and WVPEIA subsequently withdrew their requests for hearing and the Authority found that Richard D. Lindsay did not qualify as an affected party. On August 1, 2003, the applicants were granted a CON.

On July 15, 2003, PCH and BRMC filed a letter of intent to develop a freestanding Community Hospital Comprehensive Cancer Center facility to be located at PCH. PCH proposed acquiring existing radiation therapy equipment from BRMC and

submitted a CON application on July 30, 2003. Several parties requested affected party status and requested that a hearing be conducted with respect to this application. This matter was scheduled for hearing and ultimately cancelled. To date, the matter has never been heard and is still on hold.

D. BRMC and PCH entered into agreements regarding their CON applications which were subsequently investigated by the Department of Justice

The Department of Justice (hereinafter "DOJ") sent letters to BRMC and PCH inquiring about agreements the hospitals entered into on January 30, 2003 (hereinafter called "cardiac surgery and cancer center agreements"). The agreements applied to PCH's provision of certain cancer center services and the cardiac surgery agreement concerned BRMC's plan to establish and offer cardiac surgery services. The term of the agreements was for five years after the first cardiac surgery is performed at BRMC or the first cancer patient is treated at PCH, whichever is later. By their terms, the cardiac surgery and cancer center agreements applied to the following West Virginia counties: McDowell, Mercer, Monroe, Raleigh, Summers and Wyoming; and the following Virginia counties: Bland, Giles, and Tazwell.

The DOJ contends that the cardiac surgery and cancer center agreements violate Section 1 of the Sherman Act, 15 U.S.C. § 1 and "have the effect of unreasonably restraining competition and allocating markets for cancer and cardiac surgery services to the detriment of consumers." (Complaint filed by DOJ on March 21, 2005 at ¶ 1.) The DOJ requested the following relief in its complaint: that the Court declare the cardiac surgery and cancer center agreements violate Section 1 of the

Sherman Act, 15 U.S.C. § 1 and that the Court enjoin the defendants from enforcing the agreements and to further prohibit the parties from entering into additional agreements to allocate cancer or cardiac surgery services. (Complaint at ¶ 30.)

II. ANALYSIS OF LAW

A. Applicable Law

The United States Supreme Court case Parker v. Brown, 317 U.S. 341 (1943), serves as the legal foundation of the state action antitrust defense. This "state action doctrine" immunizes anticompetitive acts if taken pursuant to state policy. The Court later refined this doctrine in a series of cases.

For example, in California Retail Liquor Dealers Ass'n v. Midcal Aluminum Inc., 445 U.S. 97 (1980) the United States Supreme Court articulated two criteria to be established before a party may qualify for immunity under the state action doctrine. First, there must be a clear articulation of the state policy in question. Second, the Court determined that the action in question must be actively supervised by the State.

With respect to the clear articulation prong, the Court held that a private party seeking Sherman Act immunity under the state action doctrine need not point to a specific detailed legislative authorization for its challenged conduct as long as the state clearly intends to displace competition in a particular filed. Southern Motor Carriers Rate Conference, Inc. v. United States, 471 U.S. 48, 64 (1985). With respect to the active supervision prong, the Court has indicated that the state's supervision cannot be

minimal. Patrick v. Burget 486 U.S. 94 (1988). Rather, the state officials must exercise ultimate control over the challenged anticompetitive conduct. Id at 101.

B. Application of existing law to BRMC and PCH

Courts have liberally applied the state action doctrine over the years.[2] This has caused both the FTC and DOJ to challenge the applicability of the state action doctrine. For example, in September 2003, the FTC issued a report analyzing the applicability of the state action doctrine.[3] This report concluded that "overly broad interpretations of the state action doctrine could potentially impede national competition policy goals." Id at p. 2. Recently, the DOJ and FTC issued a report which criticized state CON programs as promoting anticompetitive markets.[4]

Based upon comments contained in the Competitive Impact Statement, it appears that the DOJ has attempted to re-define the criteria for determining when the state action doctrine applies. However, this Competitive Impact Statement does not negate approximately fifty years of United States Supreme Court precedent. Existing law clearly provides that the actions of BRMC and PCH should qualify for immunity under the state action doctrine.

With respect to the clear articulation prong of the two part test, the Authority was clearly created to control health care costs and to prevent the unnecessary duplication

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[2] See e.g., Askew v. DCH Regional Healthcare Authority, 995 F.2d 1033 (11th Cir. 1994) and FTC v. Hospital Board of Directors of Lee County, 38 F.3d 1184 (11th Cir. 1994).

[3] Report of the State Action Task Force (Sept. 2003) available at: www.ftc.gov/OS/2003/09/stateactionreport.pdf.

[4] Improving Health Care: A Dose of Competition, (July, 2004) available at www.ftc.gov/reports/healthcare/040723healthcarept.pdf

of services. W.Va. Code § 16-29B-1. At their core, all CON programs control the development of services, or the health care market, in order to keep costs down.[5] This is especially important in West Virginia, which has a high rate of uninsured individuals who already face difficulties in accessing health care.

Therefore, the Authority controls the health care market by regulating entry into the market through its laws and regulations. W.Va. 16-2D-1, *et seq*; 65 C.S.R. 7. For example, in order to be approved for a CON, the service must be needed and consistent with the State Health Plan. W.Va. Code § 16-2D-9(b); Princeton Community Hospital v. State Health Planning and Development Agency, 328 S.E.2d 164 (W.Va. 1985). In order to demonstrate the need for a service, a party often must conduct an analysis of the level of services being offered by existing providers and project the amount of services that will be needed in the future. If existing providers are not serving the population, then an unmet need exists. At a fundamental level this controls the market and allows only those providers that can establish need to enter the market. Thus, the West Virginia health care market is regulated and growth is controlled.

In addition, the Authority has determined that in order to have a high volume, quality cardiac surgery project in Southern West Virginia, hospitals must coordinate their efforts. In the newly revised State Health Plan Cardiac Surgery Standards, the Authority gave preference to joint applicants in this geographic area. BRMC and PCH filed a joint application for the development of cardiac surgery services which was ultimately approved. Previously, an individual application filed by BRMC was denied.

[5] W.Va. Code § 16-29B-26 provides state antitrust immunity for the actions of health care providers under the Authority's jurisdiction, when such actions are made in compliance with orders, directives, rules or regulations issued or promulgated by the Authority's Board.

The recently newly approved joint application will allow residents in Southern West Virginia to benefit from a quality program in close proximity to their homes.

With respect to the active supervision prong, the Authority clearly has on-going supervision of West Virginia acute care hospitals. For example, the Authority establishes, on a yearly basis, the average charge per non governmental discharge that all acute care hospitals in the state may charge. The Authority has the power to impose significant penalties on those hospitals that do not comply with the Authority's established rates. The Authority has the power to collect financial disclosure from all covered entities, which includes acute care hospitals, in West Virginia on a yearly basis. In addition, the Authority has the right to approve or deny a CON for new institutional health services. The Authority's CON powers are very broad. Even after the CON is issued, parties must submit progress reports and request substantial compliance before a file may be closed. Further, the Authority retains oversight of a CON for at least three years after it is issued. In this regulatory environment, oversight clearly does exist.

Rather than contend with the total picture, the DOJ narrowed its focus to only the written cardiac surgery and cancer center agreements. Although the Authority does not have standing to enforce the actual agreements, these agreements served as the basis for the CON applications submitted and filed by both parties. The Authority certainly has the power to regulate the CON process as well as oversee the hospital's rates.

III. CONCLUSION

The Authority realizes that both PCH and BRMC have decided to enter into a consent decree to resolve the DOJ's investigation. The Authority's purpose in filing these comments is not to prevent this judgment from being entered, but rather is to clarify its statutory powers and set forth its opinion regarding the state action doctrine.