DEPARTMENT OF JUSTICE

Antitrust Division

United States v. Health Choice of Northwest Missouri, Inc., et al.; Public Comments and Response on Proposed Final Judgment

Pursuant to the Antitrust Procedures and Penalties Act, 15 U.S.C. § 16 (b)–(h), the United States publishes below the comments received on the proposed Final Judgment in *United States* v. *Health Choice of Northwest Missouri, Inc., et al.,* Civil Action No. 95–6171–CV–SJ–6, United States District Court for the Western District of Missouri, together with the response of the United States to the comments.

Copies of the response and the public comments are available on request for inspection and copying in Room 215, Liberty Place Building, Antitrust Division, U.S. Department of Justice, 325 Seventh Street, NW., Washington, DC 20530, and for inspection at the Office of the Clerk of the United States District Court for the Western District of Missouri, 200 United States Courthouse, 811 Grand Avenue, Kansas City, Missouri 64106.

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In the United States District Court for the Western District of Missouri

United States of America, Plaintiff, vs. Health Choice of Northwest Missouri, Inc., Heartland Health System, Inc., and St. Joseph Physicians, Inc., Defendants. Case No. 95–6171–CV–SJ–6.

United States' Response to Public Comments

Pursuant to the requirements of the Antitrust Procedures and Penalties Act, 15 U.S.C. § 16 (b)–(h) (''Tunney Act''), the United States hereby responds to the public comments received regarding the proposed Final Judgment in this case.

I

Background

On September 13, 1995, the United States filed the Complaint in this matter. The Complaint alleges that Defendants, in violation of Section 1 of the Sherman Act, 15 U.S.C. § 1, conspired to prevent the development of competitive managed care health plans in Buchanan County, Missouri by, among other things, negotiating fees on behalf of most of the physicians in Buchanan County and forming an unlawfully structured physician-hospital organization. Complaint ¶¶ 24 and 25.

Simultaneously with the filing of the Complaint, the United States filed the proposed Final Judgment, a Competitive Impact Statement (''CIS''), and a Stipulation signed by all the parties that allows for entry of the Final Judgment following compliance with the Tunney Act. The CIS explains in detail the provisions of the proposed Final Judgment, the nature and purpose of these proceedings, and the practices giving rise to the alleged violation.

As the Complaint and CIS explain, 85% of all the physicians living or practicing in Buchanan County agreed to negotiate collectively fees and other contract terms with managed care plans seeking to enter Buchanan County, with the purpose and effect of increasing physician fees and controlling the development of competitive managed care health plans in Buchanan County. Together with the only hospital in Buchanan County, they also formed Defendant Health Choice of Northwest Missouri, Inc. (''Health Choice'') to provide managed care. At no time did the competing physicians share financial risk or otherwise integrate their practices.

Since the formation of Health Choice and until the filing of the Complaint, no managed care plan had been able to enter Buchanan County without contracting with Health Choice, despite the efforts of several plans to do so. By refusing to deal with managed care plans seeking to enter Buchanan County except through Health Choice, Defendant Heartland System, Inc. (''Heartland'') and the physicians belonging to Defendant St. Joseph Physicians, Inc. (''SJPI'') were able to obtain higher compensation and a more favorable hospital utilization review program from managed care plans than they would have been able to obtain independently.

The overarching goal of the proposed Judgment is to prevent Defendants from discouraging the development of competitive managed care in Buchanan County, while still permitting defendants to market a provider-controlled plan. The proposed Final Judgment consequently deals with a wide range of activities.

Except for publishing the comments and this response in the Federal Register, the plaintiff and defendants have completed the procedures the Tunney Act requires before the proposed Final Judgment may be entered.[1] The 60-day period for public comments expired on December 4, 1995. As of March 27, 1996, the United States had received 155 comments.

The comments come from a variety of sources. The most comprehensive comments were submitted by the Coalition for Quality Healthcare (''Coalition''), which describes itself as a group of health care providers and consumers in Northwest Missouri (Comments 19, 34 and 82).[2] Another substantial comment is Comment 51, the comment of an unnamed ancillary services provider (*i.e.,* provider of home health care, hospice care, outpatient rehabilitation services, or durable medical equipment) located outside of Missouri. Nine comments were submitted by Buchanan County citizens,[3] in addition to 16 comments from Buchanan County ancillary services providers.[4] A total of 105 comments were submitted by either ancillary services providers' trade associations or individual ancillary services providers located outside of Buchanan County.[5] Finally, 19 comments were submitted by hospitals located outside of Buchanan County.[6]

II

Response to Comments

A. Overview

None of the comments oppose the main provisions of the proposed Final Judgment (Sections IV (C) and (D), V (C) and (D), and VI(B)). Only one, Comment 41, suggests that the Judgment fails to redress the violation of federal antitrust laws alleged in the Complaint. That Comment, and one other dealing with the composition of the Health Choice provider panel (Comment 2), are addressed in Subsection B below.

The remaining 153 comments relate almost exclusively to how the proposed Final Judgment deals with Heartland's referral policy regarding ancillary services, a copy of which is attached to the proposed Final Judgment. Most of these comments urge that the ancillary services referral policy should either be changed or deleted from the Judgment.

[1] The United States plans to publish the comments and this response promptly in the Federal Register. It will provide the Court with a Certificate Of Compliance With The Requirements Of The Antitrust Procedures And Penalties Act and file a Motion For Entry Of Final Judgment once publication is made.

[2] The United States on January 19, 1996, numbered, indexed, and lodged with the Court all 143 comments it had received as of that date. For ease and convenience, the government in this Response refers to individual comments by those assigned numbers. The attached supplemental log lists the numbers assigned to the additional 12 comments the United States received from January 19 to March 27, 1996.

[3] Comments 1, 7–8, 11, 15–16, 25, and 142–143.

[4] Comments 3–6, 9–10, 12–14, 17–18, 20–21, 53, 151, and 155.

[5] Comments 22–24, 26–27, 29–33, 36–40, 42–50, 52, 54–56, 60–71, 74–81, 83, 85–128, 130–133, 136–141, 144, and 154.

[6] Comments 28, 35, 57–59, 72–73, 84, 129, 134–135, 145–150, and 152–153.

They raise five different antitrust issues that are addressed in Subsections C through G below.

Finally, Subsection H addresses the Coalition's contentions about the provisions of the proposed Final Judgment limiting Heartland's acquisition of physician practices (Comments 34 and 82). Subsection I addresses the Coalition's objections to the Judgment's compliance provisions (*Id.*).[7]

B. The Provider Panel Provisions Adequately Protect Competition

Commenter David L. Hutchinson of East Lansing, Michigan, Comment 41, suggests that the proposed Final Judgment will not be effective in allowing for the development of competitive managed care in Buchanan County because the Judgment permits too many Buchanan County physicians to participate on the Health Choice provider panel. In particular, Mr. Hutchinson is concerned because ''Health Choice still retains 85% of the physicians working or residing in the area, this is still a monopoly because the remaining 15% will not be able to adequately compete in the quantity of service which they provide.''

The United States agrees that there would be reason for concern if 85% of the physicians working or living in Buchanan County were owners of a Buchanan County managed care plan that negotiated with payers. As the CIS explains, the concern in such a situation is that there would be an insufficient number of physicians remaining in the market with the incentive to contract with competing managed care plans that might seek to enter Buchanan County, or to form their own plans. CIS at 17. This would likely increase the cost to consumers of obtaining health care services in Buchanan County.

The proposed Final Judgment, however, does not permit such a situation. The Defendants are not permitted to negotiate on behalf of competing physicians unless they meet the requirements of a qualified managed care plan. Proposed Final Judgment Sections IV (C) and (D), V (C) and (D), and VI(B). As explained in the CIS (pages 16–17), in order to satisfy those requirements, no more than 30% of the physicians in any relevant market may be owners of the plan. *Id.*, Section II(I)(2). While the plan may, if it wishes, *contract* with more, or even all, of the remaining doctors (as non-provider-owned managed care plans are able to do), the plan may do that only if it is at risk for overcharging or overutilization by those subcontracting physicians. *Id.* This ensures that there will be a substantial pool of physicians in Buchanan County who have the incentives to contract with, or form their own, rival managed care plans in Buchanan County.[8] See CIS at 17–19.

C. The Referral Policy Provision Is Appropriate and Adequate Relief for the Violation Alleges in the Complaint and Will Encourage, Not Impinge Upon, Patient Choice

Heartland's ancillary services referral policy, with which Heartland must comply under the proposed Final Judgment, essentially requires Heartland representatives to inquire if the patient has a choice of ancillary services providers and then to honor that choice. The policy is designed to ensure that the patient has the opportunity to use an ancillary services provider other than Heartland if the patient so wishes. Many commenters contend that this referral policy is not in the public interest because they believe other policies would better ensure that patients will be able to make informed choices in selecting ancillary services providers.

In opposing the referral policy of the proposed Final Judgment, the Coalition contends that the policy, ''violates a consumer/patient's right to make an informed choice among all ancillary services providers'' and that it ''enhances Heartland's capacity to monopolize the ancillary services market within Northwest Missouri and Northeast Kansas.'' Comment 82 at 2. The Coalition urges that the referral policy provision be deleted or, as an alternative, that the Court order Heartland to adopt the model referral policy that the Coalition developed after submitting its formal Comment (Comment 34) on November 21, 1995.[9] The Coalition's model policy would require Heartland to allow on its premises an ''ombudsman,'' whose ''salary and expenses could be shared equally among the competitors (including Heartland), in order to preserve the ombudsman's independence'' (Comment 82 at 17), and who would ''operate[ ] as an independent social worker'' in order to ''fully inform the patient of his options and see that the patient is given the freedom to choose any ancillary services provider.'' (Comment 82 at Exhibit 9).

Clearly, deleting the proposed Judgment's referral policy would weaken rather than strengthen the Judgment. Further, appointment of an ombudsman paid for collectively by all ancillary services providers, a novel remedy, is unnecessary here. Requiring Heartland to observe its already promulgated policy regarding referrals for ancillary services, which provides for ready access by patients to information about the full range of ancillary services providers, is a wholly effective remedy for the specific antitrust violation alleged in the Complaint and well within the reaches of the public interest within the meaning of the Tunney Act. *Cf., United States* v. *Microsoft Corp.*, 56 F.3d, 1448, 1459–60 (D.C. Cir. 1995)(decree adequate if within reaches of public interest).[10]

The Coalition is incorrect in asserting that the proposed Final Judgment ''*prevents* patients from making an informed choice regarding ancillary services.'' (Comment 82, Memorandum In Opposition To Proposed Final Judgment, at 5, emphasis supplied). The proposed Final Judgment requires that Heartland (1) must honor a physician's order of a specific ancillary services provider unless the patient overrides that decision, (2) must ask the patient if the patient has a preference for an ancillary services provider and must honor any such preference, (3) must not tell the patient about Heartland's ancillary services providers unless the patient states he or she has no preference among ancillary services providers, (4) must honor the patient's

[7] This Response addresses all of the antitrust issues and issues relating to the substance of the Complaint and proposed Final Judgment that are raised in the comments. Unrelated arguments and objections are not discussed. For example, the nine comments from private citizens in Buchanan County complain primarily about the quality of services and billing practices of Heartland. These complaints do not involve antitrust concerns, they are irrelevant to this case, and the Antitrust Division of the United States Department of Justice lacks authority to consider or address them.

[8] Comment 2, from Robert S. Keller, O.D. of St. Joseph, Missouri, argues that the Health Choice provider panel violates Medicare regulations by excluding optometrists. The proposed Final Judgment, however, does not preclude Health Choice from having optometrists or any other type of provider on its panel. Furthermore, this issue has nothing to do with the antitrust violation alleged in the Complaint, which the proposed Final Judgment seeks to remedy.

[9] The Coalition's model referral policy appears as Exhibit 9 to the Memorandum In Opposition To Proposed Final Judgment appended to the Coalition's December 1, 1995 Motion To Appear As Amicus (Comment 82), which the government is addressing as a comment.

[10] Many of the comments urged that the decree require Heartland to use a rotation system by which referrals would be distributed among Heartland and the other ancillary services providers. Such a system would eliminate or reduce competition by allocating patients and would raise serious antitrust concerns. Palmer v. BRG, Inc., 498 U.S. 46; United States v. Heffernan, 43 F.3d 1144, 1146–47 (7th Cir. 1994) (Posner, J.) (bid rotation agreement eliminates all competition among the participants and hence is even more serious than price fixing, which preserves competition in quality of service).

choice if the patient decides not to use the Heartland ancillary services providers, and, if asked, (5) must tell the patient that there are non-Heartland ancillary services providers who are listed in the telephone book, give the patient a reasonable amount of time to investigate other options, and then honor whatever choice the patient makes. If the patient again requests the names of other ancillary services providers, Heartland must name those providers.[11]

As numerous comments illustrate, there are myriad alternative provisions that could be proposed to resolve the hospital ancillary services referral issue. The government does not dispute that some of these may be reasonable alternatives. That, however, is not a sufficient reason to reject the negotiated settlement of this case, which provides adequate and appropriate relief to remedy the violation in this case and prevent its recurrence. *Microsoft,* 56 F.3d at 1460–61.

Significantly, the Complaint in this case did *not* charge Heartland with specific violations in the ancillary services market. Rather, the Complaint focuses on Heartland's efforts, along with the other defendants, to impede the development of competitive managed care health plans in Buchanan County. The ancillary services provision (Section VII(B)(1)) in the proposed Final Judgment is intended as a preventive measure to ensure that Heartland will follow its own preexisting ancillary services referral policy so that it will not abuse its market position in inpatient hospital services to restrict competition in the market for ancillary services by deterring managed care plans or other health care consumers from contracting with alternative ancillary services providers.

Finally, at least one comment suggests that the referral policy provision should be stricken from the Judgment because the Complaint does not allege a specific violation involving ancillary services but rather focuses more broadly on efforts to hamper the development of managed care in Buchanan County. Comment 82 at 2, 16. There is no requirement that the government's Complaint specifically mention Heartland's ancillary services activities in order to include ancillary services relief in the Final Judgment. Relief in a consent decree is appropriate as long as it is within the general scope of the case. *Int'l Assn. of Firefighters* v. *City of Cleveland,* 478 U.S. 501, 525 (1986).

The ancillary services provision of the proposed Final Judgment will help to prevent the recurrence of collaborative efforts to discourage the development of competitive managed care plans in Buchanan County, which is specifically alleged in the Complaint, and in the process also stop attempts to restrain competition in the provision of ancillary services to patients who are either uninsured or covered by other types of medical insurances. In particular, the ancillary services provision ensures that Heartland will honor the decisions of patients or their insurers regarding choice of ancillary services providers.[12]

D. The Referral Policy Provision Has No Preemptive Effect

Several commenters suggest that the ancillary services provision of the proposed Final Judgment will have *de jure* or *de facto* preemptive effect on other cases. This is not correct.

It is well established that ''a consent judgment, even one entered at the behest of the Antitrust Division, does not immunize the defendant from liability for actions, including those contemplated by the decree, that violate the rights of nonparties.'' *Broadcast Music, Inc. v. Columbia Broadcasting System, Inc.,* 441 U.S. 1, 13 (1979). Ancillary services providers and others consequently remain free to pursue their own federal or state antitrust or other actions against Heartland for any activity they believe is illegal, and they may seek whatever remedy they deem appropriate. The ancillary services provision in this matter, therefore, does not have any ''preemptive effect'' upon the relief claimable by any plaintiff against Heartland or any other hospital, and would not prevent a court, in an appropriate case, from requiring different, or more expansive, relief.[13]

The proposed Final Judgment also does not establish a national ceiling, or even a ceiling in Buchanan County, on what can or may be in a hospital ancillary services referral policy. The ancillary services provision in the proposed Judgment is simply, on the facts and in the procedural setting of this case, adequate relief to protect against the possibility that Heartland could use its market position in inpatient services to restrict competition in the market for ancillary services.

E. Heartland May Comply With Federal or State Laws or Further Protect the Patient's Right To Choose

Several commenters have suggested that the ancillary services provision of the proposed Final Judgment conflicts with hospital accreditation standards and various federal and state laws and regulations.[14] There have also been claims that the proposed Final Judgment precludes Heartland from adopting additional measures intended to assist Heartland patients in choosing ancillary services providers. None of these claims and suggestions is correct.

Section VII(B)(1) of the proposed Final Judgment requires only those steps needed to correct or prevent competitive problems alleged or similar to those alleged in the Complaint. Heartland in addition is independently obligated to comply with hospital accreditation standards, Medicare regulations, state or federal laws, or the

[11] Heartland's attorney has told us that Heartland is considering adopting the attached revised referral policy. Basically, that policy would have Heartland personnel provide a list of Buchanan County ancillary services providers, rather than the telephone book, to patients requesting information about non-Heartland ancillary services providers. It also requires Heartland to explain to a patient who is an enrollee in a managed care plan the financial consequences to the patient of not using the plan's preferred ancillary services provider. This revision contains protections for Heartland patients in addition to those required by the Final Judgment. Adoption of the revision would not violate the Final Judgment and does not require amendment of the Final Judgment. Implementation of the revision, given the presence of other provisions in the proposed Final Judgment, would largely dispose of the objections raised in Comments 23, 27, 52, 67, 79, 94, 98, 126, and 138.

[12] Several other provisions are also incorporated into the proposed Final Judgment to ensure that patients and insurers are not coerced into using Heartland's ancillary services. Section VI(E) prohibits Heartland from forcing managed care plans in which Heartland does not have a financial interest from using Heartland's ancillary services in order to get Heartland's hospital services. Also, Section VII(B)(3) allows the United States access to Heartland's credentialing files to ascertain if Heartland has curtailed the hospital privileges of a physician employed by or affiliated with a competing managed care plan. The United States could also ascertain if Heartland had limited hospital privileges of a physician for ordering ancillary services from a vendor other than Heartland for any patient.

[13] For example, the United States has been informed by the Missouri Attorney General's Office that the Missouri Attorney General is investigating Heartland's ancillary services referral practices, and other practices, to determine their legality under the Missouri Merchandising Practices Act, § 407.020 RSMo, and the Missouri Antitrust Law, §§ 416.031 RSMo. The proposed Final Judgment does not preclude or preempt any legal action by the Missouri Attorney General, or by private parties, seeking broader injunctive relief or different types of relief under either those laws or the federal antitrust laws. Moreover, in agreeing to this proposed Final Judgment, the United States does not express any view as to whether any of the practices permitted by the Attachment to the Final Judgment would be ''unfair'' within the meaning of the Missouri Merchandising Practices Act, § 407.020 RSMo.

[14] The Coalition, for example, asserts that the ancillary services provision of the proposed Final Judgment is inconsistent with hospital accreditation standards and Medicare regulations, primarily because ''Heartland's referral policy does not allow ancillary services providers, who have an established relationship with the patient before admission to Heartland's acute care hospital, to participate in discharge planning for their patients.––.––.'' (Comment 82 at 13).

decrees in other state or federal law suits, including, if necessary, permitting outside ancillary services providers to participate in patient discharge planning. Moreover, as far as the government has been able to determine, nothing in the Heartland ancillary services referral policy, with which Section VII(B) of the proposed Final Judgment requires Heartland to comply, requires Heartland to do anything that any hospital accreditation standard or any federal or state statute, rule, or regulation of which the United States is aware prohibits. (See attached Joint Commission For Accreditation Of Healthcare Organizations accreditation standards and Medicare patient discharge planning regulations).

F. The Referral Policy Does Not Harm Heartland's Rivals or Buchanan County Consumers

The Coalition also contends that the referral provision will lead to a deterioration of competition in the provision of ancillary services in Buchanan County. *E.g.*, Comment 82 at 3–4, 10–13. But these contentions assume that before the proposed Final Judgment was negotiated, Heartland was following an ancillary services referral policy that was more favorable to competing providers than the policy put in place by the Final Judgment. In fact, the government's investigation revealed that Heartland, before accepting the proposed Final Judgment, may not have always been in compliance with its stated policy.[15] Coalition members and Buchanan County citizens will be *better*, not worse, off as a result of the proposed Final Judgment since the Judgment will now ensure compliance.

Microsoft, supra, recently noted in a strikingly similar context that ''[w]hile the district court may inquire into whether a decree will result in any *positive* injury to third parties * * *, in the absence of such injury, it should not reject an otherwise adequate remedy simply because a third party claims it could be better treated.'' 56 F.3d at 1461 n.9 (emphasis supplied). There was no positive injury to third parties in *Microsoft*, and there is none in the present case. In fact, competitors and consumers are benefited by the proposed Final Judgment.

G. The Ancillary Services Relief is Consistent With the Federal Antitrust Laws

Comment 51 suggests more explicitly than any of the other comments that the Heartland Referral Policy, which Section VII(B)(1) of the proposed Final Judgment requires Heartland to follow, is inconsistent with the federal antitrust laws, and more particularly, with *Key Enterprises, Inc.* v. *Venice Hospital*, 919 F.2d 1550 (11th Cir. 1990), *vacated, reh'g en banc granted*, 979 F.2d 806 (11th Cir. 1992), *order granting en banc review vacated*, 9 F.3d 893 (11th Cir. 1993 (per curiam), *cert. denied sub nom. Sammett Corp.* v. *Key Enterprises, Inc.*,__U.S.__, 114 S.Ct. 2132 (1994). Relying on the later-vacated *Key Enterprises* decision, this comment contends that Heartland should be required to disseminate information about its ancillary services competitors, and to allow such competitors access to Heartland's hospital patients. Anything less would be, in the words of the Comment, ''inconsistent with federal antitrust policy. * * *'' Comment 51 at 2.

The ancillary services provision of the proposed Final Judgment is consistent with both the federal antitrust laws and *Key Enterprises*. *Key Enterprises* was never finally resolved by the courts. A panel of the Court of Appeals reversed a trial court order that had overturned a $2.3 million jury verdict in favor of a durable medical equipment supplier who claimed that a hospital with 76% of the available beds in a local market had violated Sections 1 and 2 of the Sherman Act by coercing or unduly influencing home health agencies in that community to refer their patients to a durable medical equipment supplier in which the hospital had a financial interest. 919 F.2d at 1553, 1555. Significantly, no injunctive or other equitable relief was at issue in *Key Enterprises*. The case was vacated after the Eleventh Circuit granted rehearing *en banc* and then settled prior to *en banc* review.[16]

Moreover, as noted earlier, this case is not about ancillary services markets. Heartland was not charged with restraining trade in or monopolizing any ancillary services market. Rather, Heartland was charged with conspiring with physicians to discourage the development of competitive managed care in Buchanan County. The ancillary services provision of the proposed Final Judgment is prophylactic, intended simply to prevent Heartland from exploiting its position in additional ways. The provision is effective and well within the bounds of the public interest. Nothing in *Key Enterprises* or any other decision requires this Judgment to contain any more relief than it does.

H. The Physician Practices Acquisitions Provisions are Adequate To Remedy the Violation Alleged in the Complaint

The Coalition criticizes the provisions of the proposed Final Judgment that place limits and controls on Heartland's acquisition of physician practices. Comment 34 at 6; Comment 82 at 18–19. The Coalition argues that ''the practical effect'' of three of those provisions, Sections VIII(B)–(D), will be to allow Heartland to ''monopolize the market for primary care physicians in Northwest Missouri and Northeast Kansas. * * *'' Comment 82 at 19.

The Judgment's physician practices acquisitions provisions, Sections VI(D) and VIII(B)–(D) of the decree, are, in conjunction with the physician credentialing provision of the proposed Final Judgment (Section VII(B)(3)), sufficient to ensure the development of conditions that permit the growth of competitive managed care in Buchanan County. They certainly will not promote the monopolization of primary care physician services in Northwest Missouri or Northeast Kansas.

Section VI(D) is the primary provision in the proposed Final Judgment regarding physician practices acquisitions. CIS at 20. It enjoins Heartland from acquiring during the next five years additional existing family practice and general internal medicine physician practices in Buchanan County without the prior written approval of the United States, and from acquiring any other existing active physician practice in Buchanan county without 90 days' prior notification. Section VI(D) was designed to, and will, prevent Heartland from obtaining control of so many physicians that it could raise prices for physician services above competitive levels or otherwise thwart competing managed care plans from entering and competing effectively in Buchanan County.

Sections VIII(B)–(D) set forth the exceptions to Section VI(D). Section VIII(B) allows Heartland to acquire the practice of a physician who derives only limited revenues (less than 20% of total

[15] This may be why Heartland's ancillary services rivals lost referrals. See Comment 82 at 12–13. If so, the proposed Final Judgment will correct the problem. Of course, another explanation for this loss of referrals may be that Heartland began offering better care and service, *i.e.*, that it was successfully competing on the merits. This would be lawful competition properly left in place by the proposed Final Judgment. Cargill, Inc. v. Monfort, Inc., 479 U.S. 104, 116 (1986).

[16] At least four courts have refused to consider *Key Enterprises* because it has been vacated: Pacifica Kidney Center, Inc. v. National Medical Care, Inc., 1993 WL 190858 (9th Cir. 1993) (unpublished disposition) at **4 n. 3; Home Health Specialists, Inc. v. Liberty Health System, 1994–2 Trade Cas. ¶ 70,699 (E.D. Pa. 1994) at p. 72,794; Atlanta Pulmonary Diagnostic Clinic v. Haynes, 1994 WL 258260 (N.D. Ga. 1994); and Northwest Title And Escrow Corp. v. Edina Realty, Inc., 1994–1 Trade Cas. ¶ 70,485 (D. Minn. 1993).

practice revenues) from patients in Buchanan County (*i.e.*, the established physician working primarily outside of Buchanan County and hence whose practice has little competitive impact in Buchanan County). Section VIII(C) allows Heartland to acquire within the first two years of a physician's arrival in Buchanan County the practice of any physician who Heartland actively recruited to Buchanan County (*i.e.*, the new physician who would not have come to Buchanan County but for Heartland and whose practice is not yet sufficiently established to have an independent competitive impact on the market). Section VIII(D) allows Heartland to acquire the practice of any family practice or general internal medicine physician already in Buchanan County who otherwise would no longer practice primary care medicine in Buchanan County (*i.e.*, the established physician working primarily in Buchanan County whose practice may have a significant independent competitive impact on the market but who is otherwise going to exit the market).

None of these three limited exceptions will result in the monopolization or a substantial lessening of competition in the physician services market in Buchanan County. Rather, Sections VI(D) and VIII (B)–(D), in conjunction with the physician credentialing provision (Section VII(B)(3)), will ensure that Heartland does not achieve by acquisition or credentialing the anticompetitive result (preventing the development of competitive managed care) that it initially sought to accomplish through agreement with the physicians of Buchanan County, and which is at the heart of the antitrust violation alleged in the Complaint. These provisions will result, at least for the near future, in the continued presence, if not the increase, of a substantial pool of primary care and other physicians not employed by Heartland in Buchanan County.[17]

That continuing pool of primary care and other physicians not employed by Heartland will also protect competition in ancillary services markets in Buchanan County. Comment 34 at 2, 5, 6; Comment 82 at 19. The Coalition correctly notes that many hospitalized patients look to their physician to recommend an ancillary services provider. Comment 34 at 2. There is consequently likely to remain during the term of this Judgment a substantial stream of ancillary services referrals from doctors who are not employed by Heartland and who therefore will not automatically refer their patients to Heartland's ancillary services providers.

Furthermore, the referral policy with which Heartland must comply (Section VII(B)(1) of the decree) will significantly curtail any adverse impact on competition in ancillary services in Buchanan County from possible future Heartland purchases of Buchanan County physician practices. The policy specifically requires Heartland to ask, and honor, a hospitalized patient's choice of ancillary services provider. Heartland must do that even if the patient's choice is different from the doctor's and the doctor is an employee of Heartland.

The Coalition also suggests that the proposed Final Judgment is deficient because it does not prohibit Heartland from bringing into Buchanan County a physician who has not previously practiced there. Comment 34 at 6; Comment 82 at 18. By increasing the supply of physicians in Buchanan County, such conduct could be procompetitive. The proposed Final Judgment therefore does not proscribe this activity. The United States, moreover, remains free to challenge such actions in the future in a separate, independent antitrust action if this activity should prove to be anticompetitive.

I. The Compliance Provisions Are Sufficient

The Coalition also believes that two of the compliance provisions of the proposed Final Judgment, Sections X and XI, should be modified to (1) require the defendants to submit written reports and the United States to conduct at least annual inspections, and (2) give the Court broader powers to monitor and enforce the Judgment as Judge Oliver required in *United States* v. *Associated Milk Producers, Inc.*, 394 F. Supp. 29, 46 (W.D. Mo. 1975). Comment 34 at 7; Comment 82 at 19–20. The United States believes that the compliance provisions of the proposed Final Judgment as they now stand are fully adequate to deter, detect, and correct any decree violations.

Sections X and XI of the proposed Final Judgment are standard judgment compliance provisions that the government has used repeatedly in its consent decrees and litigated judgments over the 20 years since *Associated Milk Producers* was entered. They include the requirement that Defendants obtain from their appropriate personnel, and maintain for the government's inspection, annual written certifications that each such person (1) has read and agrees to abide by the Judgment, (2) understands that noncompliance with the Judgment may result in criminal contempt of court, and (3) has reported any violation of the Judgment to counsel for that Defendant.[18] Furthermore, Section XII of the proposed Final Judgment, another standard decree compliance provision, allows the government to (1) inspect and copy records or documents of any of the Defendants relating to matters contained in the Judgment, (2) interview personnel of any of the Defendants about such matters, and (3) require any of the Defendants to submit written reports, under oath if necessary, about any such matter.

The commenters do not suggest that these customary judgment compliance provisions have been inadequate to uncover and remedy decree violations in the government's earlier judgments. Nor do they offer any reason to expect a different result here.[19] The government will not hesitate, as the proposed Final Judgment permits (Section IX), to seek a modification of Sections X and XI if these provisions in practice prove to be inadequate to properly enforce this decree.

III

The Legal Standard Government the Court's Public Interest Determination

Once the United States moves for entry of the proposed Final Judgment, the Tunney Act directs the Court to determine whether entry of the proposed Final Judgment ''is in the public interest.'' 15 U.S.C. § 16(e). In making that determination, ''the court's function is not to determine whether the resulting array of rights and liabilities is one that will *best* serve society, but only to confirm that the resulting settlement is within the *reaches* of the public interest.'' *United States v. Western Elec. Co.*, 933 F.2d 1572, 1576 (D.C. Cir.), *cert. denied*, 114 S. Ct.487 (1993) (emphasis added, internal quotation and citation omitted).[20] The Court should evaluate the relief set forth in the proposed Final Judgment and should enter the Judgment if it falls within the

[17] By its terms, this provision would not apply if any firm other than Heartland made a bona fide offer to purchase the practice for a price above the liquidation value of the practice. 4 CCH Trade Reg. Rpt. ¶13,104 at 20,574.

[18] The *Associated Milk Producers* decree, even as supplemented by Judge Oliver, did not contain this provision. 394 F. Supp. at 49–58.

[19] Indeed, Judge Oliver in a subsequent government antitrust consent decree did not order these supplemental provisions. United States v. Mid-American Dairymen, Inc., 1977–1 Trade Case. ¶ 61,508 (W.D.Mo. 1977).

[20] The *Western Electric* decision concerned a consensual modification of an existing antitrust decree. The Court of Appeals assumed that the Tunney Act was applicable.

government's ''rather broad discretion to settle with the defendant within the reaches of the public interest.'' *Microsoft,* 56 F.3d at 1461. *Accord, Associated Milk Producers,* 534 F.2d at 117–18.

The Court is not ''to make *de novo* determination of facts and issues.'' *Western Elec.,* 993 F.2d at 1577. Rather, ''[t]he balancing of competing social and political interests affected by a proposed antitrust decree must be left, in the first instance, to the discretion of the Attorney General.'' *Id.* (internal quotation and citation omitted throughout). In particular, the Court must defer to the Department's assessment of likely competitive consequences, which it may reject ''only if it has exceptional confidence that adverse antitrust consequences will result—perhaps akin to the confidence that would justify a court in overturning the predictive judgments of an administrative agency.'' *Id.*[21]

The Court may not reject a decree simply ''because a third party claims it could be better treated.'' *Microsoft,* 56 F. 3d at 1461 n.9. The Tunney Act does not empower the Court to reject the remedies in the proposed Final Judgment based on the belief that ''other remedies were preferable.'' *Id.* at 1460.[22] As Judge Greene has observed:

If courts acting under the Tunney Act disapproved proposed consent decrees merely because they did not contain the exact relief which the court would have imposed after a finding of liability, defendants would have no incentive to consent to judgment and this element of compromise would be destroyed. The consent decree would thus as a practical matter be eliminated as an antitrust enforcement tool, despite Congress' directive that it be preserved.

United States v. American Tel. & Tel. Co., 552 F. Supp. 131, 151 (D.D.C. 1982), *aff'd sub nom. Maryland v. United States,* 460 U.S. 1001 (1983) (Mem.).

Moreover, as noted above, the entry of a governmental antitrust decree forecloses no private party from seeking and obtaining appropriate antitrust remedies. Thus, Defendants will remain liable for any illegal acts, and any private party may challenge such conduct if and when appropriate. If any of the commenting parties has a basis for suing Defendants, they may do so. The legal precedent discussed above holds that the scope of a Tunney Act proceeding is limited to whether entry of this particular proposed Final Judgment, agreed to by the parties as settlement of *this* case, is in the public interest.

Finally, the Tunney Act does not contemplate judicial reevaluation of the wisdom of the government's determination of which violations to allege in the Complaint. The government's decision not to bring a particular case on the facts and law before it at a particular time, like any other decision not to prosecute, ''involves a complicated balancing of a number of factors which are peculiarly within [the government's] expertise.'' *Heckler* v. *Chaney,* 470 U.S. 821, 831 (1985). Thus, the Court may not look beyond the Complaint ''to evaluate claims that the government did *not* make and to inquire as to why they were not made.'' *Microsoft,* 56 F.3d at 1459 (emphasis in original); *See also, United States* v. *Associated Milk Producers, Inc.,* 534 F.2d 113, 117–18 (8th Cir. 1976), *cert. denied,* 429 U.S. 940 (1976).

Similarly, the government has wide discretion within the reaches of the public interest to resolve potential litigation. *E.g., United States* v. *Western Elec. Co.,* 993 F.2d 1572 (D.C. Cir.), *cert. denied,* 114 S. Ct. 487 (1993); *United States* v. *American Tel. & Tel. Co.,* 552 F. Supp. 131, 151 (D.D.C. 1982), *aff'd sub nom. Maryland* v. *United States,* 460 U.S. 1001 (1983) (Mem.). The Supreme Court has recognized that a government antitrust consent decree is a contract between the parties to settle their disputes and differences, *United States* v. *ITT Continental Baking Co.,* 420 U.S. 223, 235–38 (1975), *United States* v. *Armour & Co.,* 402 U.S. 673, 681–82 (1971), and ''normally embodies a compromise; in exchange for the saving of cost and elimination of risk, the parties each give up something they might have won had they proceeded with the litigation.'' *Armour,* 402 U.S. at 681.

The ancillary services provision (Section VII(B)(1)) in the proposed Final Judgment is a preventive measure to protect against the possibility that Heartland could abuse its market position in inpatient hospital services to restrict competition in the market for ancillary services by deterring managed care plans or other heath care consumers form contracting with alternative ancillary services providers.[23] This Judgment has the virtue of bringing the public certain benefits and protection without the uncertainty and expense of protracted litigation. *Armour,* 402 U.S. at 681; *Microsoft,* 56 F. 3d at 1459.

IV

Conclusion

After careful consideration of these comments, the United States concludes that entry of the proposed Final Judgment will provide an effective and appropriate remedy for the antitrust violation alleged in the Complaint and is in the public interest. The United States will therefore move the Court to enter the proposed Final Judgment once, as 15 U.S.C. § 16(d) requires, the public comments and this Response have been published in the Federal Register.

Dated: May 17, 1996.

Respectfully submitted,

[21] The Tunney Act does not give a court authority to impose different terms on the parties. *See, e.g.,* United States v. American Tel. & Tel. Co., 552 F. Supp. 131, 153 n. 95 (D.D.C. 1982), *aff'd sub nom.* Maryland v. United States, 460 U.S. 1001 (1983) (Mem.); *accord* H.R. Rep. No. 1463, 93d Cong., 2d Sess. 8 (1974). A court, of course, can condition entry of a decree on the parties' agreement to a different bargain, *see, e.g., AT&T,* 552 F. Supp. at 225, but if the parties do not agree to such terms, the court's only choices are to enter and decree the parties proposed or to leave the parties to litigate.

[22] Citing United States v. Central Contracting Co., 537 F. Supp. 571 (E.D.Va. 1982), the Coalition wrote the government in November 1995 and requested all ''determinative'' materials and documents called for by 15 U.S.C. § 16(b) (Comment 19). The United States replied that there are no such materials or documents. The Coalition suggests in Comment 82 that this response shows that ''the DOJ has not been forthcoming with disclosure of the underlying factual materials supporting the proposed policy.'' Memorandum In Opposition To Proposed Final Judgment at 5. The Coalition suggests, apparently because of *Associated Milk Producers,* that the government's response requires the Court to make a more careful review in this instance than might otherwise be the case. This approach is unwarranted in the present matter even if the Coalition's reading of *Associated Milk Producers* is correct. Here there simply are no documents which, either along or as a group, have such singular or particularized significance as to be ''determinative'' under 15 U.S.C. § 16(b). The Coalition is incorrect in suggesting that the Department never produces determinative documents. The Department has done so in 19 cases since the *Central Contracting* decision.

[23] Managed care plans in general are making greater use of competition among ancillary services providers to reduce premium costs and to reduce the number and duration of hospitalizations. *See, e.g.,* K. O'Donnell & E. Sampson, ''Home Health Care: The Pivotal Link In The Creation Of A New Health Care Delivery System, Journal of Health Care Finance, Volume 21, No. 2, pages 74–86 (1994); and G. Leavenworth, ''The Fastest Growing Segment Of The Health Care Industry Combines Cost-Effective, High—Quality Care With The Comforts Of Home,'' Business & Health, vol. 13, special issue, p. 51 (Jan. 1995).

Allen S. Vanbebber,

Deputy United States Attorney, Western District of Missouri, Suite 2300, 1201 Walnut Street, Kansas City, Missouri 64106–2149, Tel: (816) 426–3122.

Edward D. Eliasberg, Jr.,

Gregory S. Asciolla,

Attorneys, Antitrust Division, U.S. Dept. of Justice, Room 414, 325 7th Street, N.W., Washington, DC 20530, Tel: (202) 307–0808.

Certificate of Service

I, Edward D. Eliasberg, Jr., hereby certify that copies of the Response to Public Comments in *U.S.* v. *Health Choice of Northwest Missouri, Inc., et al.*, was served on the 17th day of May 1996 by first class mail to counsel as follows:

Thomas D. Watkins, Esquire, Watkins, Boulware, Lucas, Miner, Murphy & Taylor, 3101 Frederick Avenue, St. Joseph, Missouri 64506–0217

George E. Leonard, Esquire, Shugart, Thomson & Kilroy, 12 Wyandotte Plaza, 120 West 12th Street, Kansas City, Missouri 64105–0509

Richard D. Raksin, Esquire, Sidley & Austin, One First National Plaza, Chicago, Illinois 60603

Jack Briggs, Health Choice of Northwest Missouri, Inc., 510 Francis Street, St. Joseph, Missouri 64501

Brian B. Myers, Esquire, Lathrop & Norquist, 2345 Grand Avenue, Suite 2600, Kansas City, Missouri 64108

Thomas M. Bradshaw, Esquire, Dianne M. Hansen, Esquire, Armstrong, Teasdale, Schlafly & Davis, Suite 2000, 2345 Grand Boulevard, Kansas City, Missouri 64108

Glenn E. Davis, Esquire, Diane E. Felix, Esquire, Armstrong, Teasdale, Schlafly & Davis, One Metropolitan Square, Suite 2600, St. Louis, Missouri 63102–2704

Edward D. Eliasberg, Jr.

Hospital Inpatient—Ancillary Services Referral Policy

I. General Statement

After a patient or other appropriate person (collectively, ''patient'') has been identified (via screening, assessment, discharge planning, staff, family, physician, or other means) as being in need of appropriate home health, hospice, DME, or outpatient rehabilitation services (referred to collectively as ''Ancillary Service''), and, if necessary, a physician's order has been obtained, the following procedures will be used by a non-physician referring person when connecting patients to the appropriate Ancillary Service. Our focus is on patient choice.

II. Service Referrals

A. If a physician orders an Ancillary Service and specifies the provider to be used (whether specifically written in the chart or other written notification), then a referring person shall contact the patient indicating that the physician has ordered an Ancillary Service and has ordered that a particular provider be used. If necessary, the patient should be informed of any financial considerations (i.e., managed care). The patient should then be asked whether the particular provider is acceptable, and if so, referred to that provider. (If the patient does not wish that provider, see subsection B below).

B. If a physician orders an Ancillary Service, but does not specify the provider to use, then the patient shall be contacted and informed that his physician has ordered an Ancillary Service; if necessary, the patient should be informed of any financial considerations (i.e., managed care); and the patient shall be asked if he has a preference as to which provider to use:

1. If the patient has a preference, that preference shall be honored.

2. If the patient has no preference, a referring person shall indicate that Heartland has an excellent, full accredited Ancillary Service that is available to the patient, and the appropriate Heartland brochure may be given. If the patient accepts, then the referral shall be made to Heartland's Ancillary Service.

3. If the patient has not accepted Heartland's Ancillary Service (see subsection B(2) above), or asks what other providers are available, a referring person shall state that there are other providers in the community that may offer the Ancillary Service, and provide the patient with the list of providers attached. If appropriate, this list may be provided verbally. [PATIENT SHALL BE GIVEN A REASONABLE AMOUNT OF TIME TO INVESTIGATE OTHER OPTIONS.] If the patient at this point chooses a provider, that choice shall be noted on the patient's chart and the referral made to the provider chosen.

Copies of the Comments and the United States' Response to Public Comments, with all omitted attachments, are available for inspection in Room 200, Liberty Place, (202/514–2481), United States Department of Justice, Washington, DC and at the Office of the Clerk of the United States District Court for the District of Western Missouri, Kansas City, Missouri.

Lodging of Public Comments Regarding Proposed Final Judgment

United States of America, Plaintiff, vs. Health Choice of Northwest Missouri, Inc., Heartland Health System, Inc., and St. Joseph Physicians, Inc., Defendants. Case No. 95–6171–CV–SJ–6.

Pursuant to the Antitrust Procedures and Penalties Act, 15 U.S.C. §§ 16 (b)–(h) (''Tunney Act''), Plaintiff United States of America hereby lodges with the Court the comments the government has received to date from the public regarding the Proposed Final Judgment in this case.

Attached to this pleading is a log listing for each comment the date the government received the comment, the date of the comment, the name and address, if available, of the commenter, the number of pages, and a brief description of the comment.

As the log indicates, the government received six comments in which the commenter requested anonymity. While those comments have been described in the log, five of those comments have been returned to their authors. The government has explained to those authors by means of accompanying transmittal letters that comments in Tunney Act proceedings become part of the public record. The government has invited each of these authors either promptly to submit a revised comment not disclosing the author's identity or to resubmit the original comment if the author no longer objects to public disclosure of the author's identity.

The sixth comment is an anonymous handwritten letter without return address in which the author's supervisor at Defendant Heartland Health System, Inc. is specifically named and claimed to be the primary cause of the problems in this matter. That comment will not be made available to the public unless the Court desires the government to do so.

The government anticipates that it soon will be filing its response to all the comments, as required by the Tunney Act, 15 U.S.C. § 16(d).

Dated: January 19, 1996.

Respectfully submitted,

Alleen S. Vanbebber,

Deputy United States Attorney, Western District of Missouri, Suite 2300, 1201 Walnut Street, Kansas City, Missouri 64106–2149, Tel: (816) 426–3122.

Edward D. Eliasberg, Jr.,

Gregory S. Asciolla,

Attorneys, Antitrust Division, U.S. Dept. of Justice, Room 9422, 600 E Street, NW., Washington, DC 20530, Tel: (202) 307–0808.

Certificate of Service

I, Edward D. Eliasberg Jr., hereby certify that a copy of the foregoing document was served on the 19th day of January 1996 by first class mail to counsel as follows:

Thomas D. Watkins, Esquire, Watkins, Boulware, Lucas, Miner, Murphy & Taylor, 3101 Frederick Avenue, St. Joseph, Missouri 64506–0217

George E. Leonard, Esquire, Shugart, Thomson & Kilroy, 12 Wyandotte Plaza, 120 West 12th Street, Kansas City, Missouri 64105–0509

Richard D. Raskin, Esquire, Sidley & Austin, One First National Plaza, Chicago, Illinois 60603

Jack Briggs, Health Choice of Northwest Missouri Inc., 510 Francis Street, St. Joseph, Missouri 64501

Brian B. Myers, Lathrop & Norquist, 2345 Grand Avenue, Suite 2600, Kansas City, Missouri 64108

Thomas M. Bradshaw, Esquire, Dianne M. Hansen, Esquire, Armstrong, Teasdale, Schlafly & Davis, 1700 City Center Square, 1100 Main Street, Kansas City, Missouri 64105

Glenn E. Davis, Esquire, Dianne E. Felix, Esquire, Armstrong, Teasdale, Schlafly & Davis, One Metropolitan Square, Suite 2600, St. Louis, Missouri 63102–2704

Edward D. Eliasberg Jr.

Note: The following list indicates where tables, newspaper articles and attachments have been taken out, you can obtain copies of these complete documents in our Department of Justice, Premerger Office, Liberty Place Building, ATR Division, Room 215, 325 Seventh Street, NW., Washington, DC 20530.

1. Sept. 26, 1995 letter from Robert S. Keller, O.D.
2. Letter from the Administrator of St. Joseph Nursing Home
3. Anonymous note (had newspaper articles)
4. Mark L. Wyble, Coordinator, Patient & Community Relations from Total Home Health Care
5. Oct. 3, 1995 from Citadel Health Care, written by Lowell Fox, Administrator
6. Nov. 4, 1995 letter from Richard C. Bosworth, R.Ph., Coalition of Quality Health Care
7. Nov. 20, 1995 letter, Hill Country Health Services, Inc., from Ron Julian, Administrator.
8. Nov. 19, 1995 letter, from Dennis O. Davidson, M.D.
9. Nov. 23, 1995, Home Health Insights, Inc., from Ross Feezer
10. Nov. 27, 1995, Shepard's Crook Nursing Agency, Inc., from Suzanne Wilkinson, Administrator/Owner
11. Nov. 27, 1995, Metro Home Health Care Services, Inc., from Richard A. Porter, President/Administrator
12. Nov. 29, 1995, Kevin Miller, RRT, RCP
13. Dec. 4, 1995, Gibson Health Services, from Patricia A. Gibson, RN, MPH
14. Dec. 4, 1995, Heritage Home Health Inc., from Matthew F. Komac
15. Nov. 21, 1995, Metro Home Health Care Services, Inc. from Richard A. Porter
16. Anonymous letter (had clippings)
17. Feb 28, 1996, Missouri Alliance for Home Care, from Dale E. Smith

September 26, 1995.

Gail Kursh,

Chief, Prof. & Intellectual Prop. Section/ Health Care Task Force

Dear Ms. Kursh: I am grateful for the opportunity of writing to you regarding my concerns with reference to Heartland Health Systems here in St. Joseph.

I am a retired Senior Citizen and a patient of a Dr. in the group aligned with the hospital. I like my Dr. but don't approve of the monopoly the hospital has over the Dr.'s services as well as options given to the patients in several areas. Also, I understand the referral to specialists is down-sized. The Pres. of the hospital was quoted as saying ''he was not being paid to be stupid,'' but he is being paid to have integrity and high standard of morals.

Yours truly,

Helen Kadera

P.S. I with so many, many others are grateful that this situation is being investigated.

Optometry

Dr. Joyce Keller Stroud

Dr. Robert S. Keller

3605 Faraon Street, St. Joseph, Missouri 64506, Telephone (816) 364–2000

26 September 1995.

Gail Kursh,

Chief, Intellectual Prop. Section, Health Care Antitrust, U.S. Dept. of Justice, 600 E. St. N.W., Room 9300, Washington, D.C. 20530

Dear Ms. Kursh: It is my hope that you have received a copy of the St. Joseph News Press of 24 September 1995.

I want to point out that the Heartland Hospital new HMO, called Community Health Plan, is excluding Optometry in providing eye health care to its members.

I refer to total eye health, with the exception of surgery. Optometrists can treat most eye health conditions and recently in Missouri, that included glaucoma.

Since 28 August 1995, I have sought an opportunity to appear before the Board of Community Health Plan to point out that Medicare and Medicaid utilize the services of Optometry to the fullest extent of their licensure.

Enclosed is a copy of the regulations defining the scope of the various professions. Heartland is in the process of being the gatekeeper for Medicaid in our area of Missouri, and they cannot be allowed to usurp Federal Regulations or any patients right to choose.

Very truly yours,

Robert S. Keller, O.D.

Gail Kursh,

U.S. Dept Justice, 600 E St. N.W. Rm. 9300, Washington, D.C. 20530

Dear Ms. Kursh: First, we don't want to talk against our Hospital as it is good to have a hospital in our city. But we expect the Hospital to be a Hospital, and not in competition with nearly every business in our town. Other businesses such as pharmacies, medical supplies Insurances, Nursing homes, all other nursing needs, such as Home health care programs, laboratories, rehab programs, and so on, it goes on and on.

We in the nursing home and convalescent business have to go through the state of Missouri to apply for Licenses and permits to start a convalescent center, we are inspected at least twice a year, more if they see fit. We have many rules to go by. We have to be approved by the State to operate. We don't think the same rules apply. Now Heartland Health systems has taken over so many of the services we had for years here in St. Joseph—without any permission from the State of Missouri without going through the processes required for nursing facilities. They have opened a skilled and intermediate care nursing home without contacting the State or going through the process. I have talked with a Regional Manager for the Division of Social Services and told him out plight, He said we can't do anything as Hospitals can do things and we can't say anything to them. There surely is some regulations for them as well as anyone else.

As of now in St. Joseph, MO. if the doctors don't belong to Heartland Health Systems, they can't take their patients there, which is double expense. A Doctor used to be in his office and the patient went there first, then if they needed hospitalization, fine, otherwise the Doctors office was cheaper. Also now if you need medications, the Doctors goes through Heartlands Pharmacy which cuts our own Hometown pharmacies. Our St. Joseph Surgical Supply is having a rough time, our suppliers of Health Care are all suffering and all nursing Homes are really hurting. Our facility alone is over 40 patients down and if we call a Doctor about anyone who is sick, they immediately say send them to the Hospital, we'll check them out here, which is very expensive. The ambulance service here is terribly expensive and is

owned by Heartland Health systems. This is another reason the Medicare program is suffering and Doctors could come to the Nursing facilities to see their patients as in the past but they seldom do that now.

Mr. Kruse not only has bought up the Drs. offices and buildings and clinics around St. Joseph and areas outside of St. Joseph, the Doctors had to join Heartland in order to use the hospital. An official of our State, said it would be good for the government to look into other hospitals he has worked for.

If all our nursing homes are forced to close, it would be a big loss to our city businesses, where we buy our supplies, also the employees would be out of work and we as business owners would be hurt. The banks that loaned us money to build and operate.

I understand the money Heartland's loans come from outside the St. Joseph area.

The min trouble we have with Heartland is the when we send our patients to them as have for years, instead of returning them to us for their rehab, and care, they are transferring them to their skilled and intermediate care units, until there Medicare days are used.

Two of our employees have met and talked with Heartlands Social Service Dept. they made the remark, ''we have to send them to our nursing home, we don't have a choice.

Their Social Service Dept. call daily to check on vacancies, of which we have 40. However refferals are few and far between. In the past the majority of our patients came from the hospital.

We in the health care business in St. Joseph are all hurting, we appreciate any effort to stop Heartlands monopoly.

Sincerely;

Administrator St. Joseph Nursing Home.

Dear Sir: We are all so very upset—We owe thousands of dollars on our nursing home—It's rather new & the bank didn't want to loan money to a nursing home they didn't feel secure because of something that happened years ago—Finally they did—Now this we are down over 40 beds & no hope. If we call & doctor he tells us to send them out to the hospital & he'll see them. Ambulance is $400.00 just for that. Then they keep the patient & put the patient in their nursing home. This is in all nursing homes in St. Joseph—All pharmacies are suffering, all supply companies are suffering. Will you please help us in St. Joseph. Please, please.

Beltone Knapp Hearing Aid Center

1150 South Belt Highway, St. Joseph, MO 64507, (816) 232–3386, FAX: (816) 232–4362

Sept. 29, 1995.

Gail Kursh,

Chief, Professions & Intellectual Property Section/Health Care Task Force, Anti-trust Division, U.S. Dept. of Justice, 600 E. Street, N.W., Room 9300, Washington, D.C. 20530

Re: Heartland Hospital Comments

Dear Gentlemen: On Sept. 24th, 1995 the St. Joseph News-press ran an article on the Heartland Hospital's problem and potential problems with both the federal and state governments.

In this geographical area we have only one hospital, and one physicians office that specializes in problems of the ear. At least one other ear specialist was purported to have been forced out.

It is our understanding that any patient who has any questions of possible hearing problems is tested and if over 65 is billed to medicare. If there is a loss, they are sold hearing aids by the hospital. To our knowledge they are not given a choice or advised of the many immediate and long term benefits of being fitted by a dispenser other than the hospital.

If there is to be true competition than this system needs some changes.

Sincerely,

Roger E. Knapp,

President.

October 4, 1995.

Gail Kursh,

Health Care Task Force, Department of Justice, Antitrust Division, 600 E Street, N.W., Room 9300, Washington, D.C. 20530

Dear Ms. Kursh: As an 18 year employee of a Nursing Facility in St. Joseph Mo., I am writing in regard to the Anti Trust Suit against Heartland Health Systems in St. Joseph.

In the 18 years that I have been at this facility we have more vacancies as this time than we have ever had. We feel it is still the monopolization of Heartland. If we send a patient to the hospital they are treated in the acute hospital, transferred to extended care for rehab, until their Medicare days are used. Sometimes they are then transferred to the Medicaid unit. The nursing homes in St. Joseph all have rehab available and there really isn't any reason for patients to remain in the Hospital for the length of time they are kept. I believe it is abusing Medicare and Medicaid as well as private insurance. This did not happen in the past, only under the present management.

They have bought the Drs. groups, this has caused a trickle down effect in our city. It has affected everyone in the Health Care Industry. Heartland now has a 210 bed nursing facility, when there are many vacancies in the nursing homes in this area. If you use the Doctors they have bought, you use Heartlands Pharmacy, Laboratory, exray, and supplies. This has even gone so far as to hurt office supply businesses, as the Doctors in the past have bought their office supplies from the local businesses, now they buy through Heartland.

As far as Nursing Homes go, we all have vacancies and can't see there was a need for 210 beds at Heartland. I understand they will be adding an Alzhiemers Unit. There is a total of 500 beds available, when these are utilized, how many vacancies will we have and how many homes will be forced to close.

We were of the opinion it was against the law to have a monopoly. Heartland definitely has a monopoly in St. Joseph.

We have written the Justice Department in the past, as of this date we can see no difference in Heartlands attempts to monopolize the Health Care providers in Buchanan County and Northwest Mo. Finally the summary I read does not rectify the monopoly Heartland already has. Doctors, laboratories, pharmacies, long term care, suppliers, and home health.

We remain optimistic that the anti-trust department can help the providers in and around our area.

Sincerely,

Dee Frye,

P.O. Box 1308, St. Joseph, MO 64502.

I am writing in reference to a newspaper article concerning Heartland Health System of St. Joseph, MO.

I have had quite a few bad dealings with the doctors in St. Joseph and Heartland Health System and Physician's acute care services—which are affiliated with Heartland.

Our insurance provider is Health Net, which my husband carries through his employer.

I have seen numerous instances of poor patient care, medical negligence, mis-diagnosis and probable medical malpractice. Over-billing of patient accounts and trying to get more money out of the patient, than the insurance says we have to pay.

Another area you may want to check into is the med-clinic which is a doctor-owned clinic in St. Joseph.

Patients who have went to the clinic for a problem are given inaccurate lab results and inaccurate diagnosis and told to come back to be rechecked again, and when these patients go to their regular doctor there is nothing wrong with them.

I live 25 miles north of St. Joseph, and my family drives 70+ miles to use a hospital in Kansas City. The care is so bad at Heartland, I wouldn't take a dog there. I hope we never have a life threatening emergency—they probably wouldn't make it to Kansas City, but they would be better off, than going to Heartland.

Sincerely,

Alona S. Miller,

20421 County Road 223, Union Star, MO 64494.

October 3, 1995.

Professions and Intellectual Property Section, Health Care, Task Force,

Anti Trust Division, U.S. Department of Justice, 600 E Street N.W., Room 9300, Washington, D.C. 20530

Attention: Gail Kursh, Chief

Dear Ms. Kursh: Recently in the St. Joseph Newspress the article on HEARTLAND HOSPITAL, St. Joseph, Missouri pertaining to the anti-trust suit that is pending against them.

You might find it very interesting to the treatment that a local doctor * * * Dr. Charles Willman received from them. He filed law suits again the hospital and some doctors but was unable to get by the Judge Bartlett in Kansas City and also unable to be heard in Jefferson City, Missouri. Dr. Willman was a very fine surgeon and was my person doctor. They refused him practice at the hospital and you might find it very helpful if you investigated this case.

Dr. Willman gave up his practice and now lives in Springfield, Missouri due to financial reasons.

Sincerely yours,

Joy Schiesl,

Five Lindenwood Lane, St. Joseph, Missouri 64505.

Bender's Total Home Health Care

3829 Frederick Avenue, St. Joseph, Missouri 64506, 816/279–1668, 800/633–9781, Fax 816/279–6425

Gail Kursch,

Dept. of Justice, Antitrust Division, 600 E Street NW, Room 9300, Washington, DC 20530

This is to make you aware of a grave concern we and others (providers and patients) have regarding the new Referral Policy of Heartland Health Systems. That policy, as stated in the proposed Final Judgment against Heartland Health Systems, HealthChoice of Northwest Missouri and St. Joseph Physicians Inc. by the U.S. Justice Dept., has clearly been developed to serve the best interests of Heartland and its subsidiaries, and certainly *not* the best interests of patients. Not only are patients unlikely to be given an equal, unbiased choice of providers, the new policy *guarantees* that patients *will not* be given unbiased information or assistance with which to make necessary decisions.

There are several reputable providers of home health care, hospice, home medical equipment, oxygen and outpatient rehabilitation services serving St. Joseph and the surrounding area. In an effort to achieve total vertical integration, Heartland has created subsidiaries to fill each of these ancillary services. In doing so, *Heartland has become a direct competitor with each of the independent providers for whom Heartland is the primary referral source.* To further control referrals, Heartland also now ''owns'' an HMO, an managed care agency and several physicians' practices.

While being ripe for abuse, this situation is not of itself necessarily harmful to independent providers nor to patients. Actually, we contend that fair competition encourages providers to improve the service they render and to hold down costs, which ultimately benefits consumers. However, the procedures which Heartland's discharge planners have been ordered to follow *are* harmful to the ultimate consumer good by preventing fair competition.

The previous referral policy was that every patient for whom ancillary services were ordered would be made aware of all area providers of the required service(s) in an unbiased way. Should a patient have questions about any of these, the discharge planner, working on the patient's behalf, would seek accurate information. This policy, if followed, would foster fair competition; would encourage providers to compete based on merit, not artificial barriers or deal-making; and most importantly, would benefit patients.

The new policy states that if a patient does not express a preference of provider, the discharge planner shall make a sales pitch for Heartland's own service. If the patient does not accept Heartland's Ancillary Service or asks what other providers are available, they shall be told to look in the telephone book. Only if the patient asks again for information on other providers are the referring personnel to verbally (not in writing) identify the independent providers that can serve the patient's needs. At no time is the discharge planner to act on the patient's behalf by providing impartial information that would facilitate the patient choosing one of Heartland's competitors.

Obviously, this new policy blatantly prevents free, informed patient choice by denying equal access to information. Discharge planners who should be impartial patient advocates are turned into agents for heartland's ancillary services. No other provider is allowed to put literature into the hands of patients. No other provider is allowed access to patient charts. No other provider's capabilities can even be outlined to patients and families who could benefit from their service.

We do not expect each independent provider to be allowed to walk the halls ''fishing'' for patients or to give an aggressive sales pitch to every patient that is admitted. What *is* expected is fairness. Equal access to accurate information by patients and impartial efforts by those who are supposed to be assigned (and allowed) to serve the best interests of the patient—not those of Heartland. Heartland's Ancillary Services should be treated no better or worse than any other provider, but should compete for the opportunity to serve the needs of the patient based upon merit. Give the patients equal, unbiased information and impartial assistance and let them choose.

We have no complaint against hospital personnel, in fact most with whom we have had dealings over recent years (as patients and as a provider of products/services) have been extremely efficient and helpful. Our concern is with the new policy which, not only threatens the viability of independent businesses, but betrays the trust of unsuspecting patients who assume that their interests are being handled by impartial sources.

Mark L. Wyble,

Coordinator, Patient & Community Relations.

October 9, 1995.

Gail Kursh,

Chief, Professions & Intellectual Property Section, Health Care Task Force, Anti-trust Division, U.S. Department of Justice, 600 E Street, N.W., Room 9300, Washington, D.C 20530

Dear Gail Kursh: I recently saw an article in the St. Joseph newspaper indicating that the Justice Department was accepting written comments on the proposed consent decree concerning Heartland, Health Choice and St. Joseph Physicians, Inc.

What I cannot understand is how Heartland Health Systems, the parent of all these organizations, and supposedly a non-profit organization, can contribute over three million dollars to the purchase and development of land for an industrial park in St. Joseph.

If Heartland Health Systems has that much extra money to throw around then whatever they are doing must be a real serious violation of the anti-trust laws and should require more serious penalties than the slap on the wrist they are receiving in the consent decree.

A concerned citizen of St. Joseph, Missouri

Coalition for Quality Healthcare

October 10, 1995.

To all who have been affected by Heartland's business practices, both providers and patients:

We are a group of business professionals and citizens concerned about the fairness in the healthcare market in St. Joseph.

We Want Our Voice To Be Heard

The Justice Department recently filed in district court a ''Final Judgment'', which, according to the competitive impact statement filed with it ''* * * will restore the benefits of free and open competition in St. Joseph and will provide consumers with a broader selection of competitive health care plans.''

The Coalition for Quality Healthcare, and other concerned citizens, want you to become familiar with the ''proposed Final Judgment.'' The United States District Court for the Western District of Missouri has filed this civil action suit against Heartland Health Systems, Health Choice of Northwest Missouri, Inc., and Physicians, Inc., on September 13, 1995. After 60 days, (November 13, 1995) this Final Judgment will be entered into court. Once finalized, no changes will be allowed into the decree for a 5-year period. We believe that the proposed final judgment should be modified and clarified before it has been filed and entered by the court.

Appropriate steps are needed to ensure equal access and to foster patient care. In order to ensure equal access to available services provided by many sources other than Heartland, as well as adequate patient choice in obtaining those services, we believe that certain restrictions need to apply to Heartland Health Systems. These restrictions would serve to foster and support cost reduction through total market competition, and should include the following:

- Strengthen limitations on the hospital's ability to refer its patients to its own hospital-based components.
- Require the hospital to use a rotation system, which assures equitable referrals to all providers in the area. A legislated rotation system would guarantee that hospital staff could not unfairly influence hospitalized patients in the selection of necessary providers and would provide a means of accountability.
- Require the hospital to permit (on their premises, during normal working hours) representatives of freestanding providers—other than their own hospital-based components—to visit their patients who have been admitted for hospitalization; and to expose the patient population to the availability of outside services as well.
- In order to ensure compliance with the above, make the hospital post, for public examination, their daily referrals to both their hospital-based component and to other providers in the community.

Situation

It is time we made the hospital accountable for their actions! They say they have a

referral policy, and they follow it * * * let's make them abide by it. Hospitals who exceed 30% of referrals to their own components, should be subject to a fine.

Recommendation

We recommend that violators be fined $50,000 per day.

What We Would Like To See

First and foremost, we would like to see the patients offered informed consent and the right to choose. We feel that all people need to be educated on this fact.

As a provider, your business may be adversely affected by Heartland's use of its monopoly power. As a patient at Heartland, you may have been ''coerced'' into using a Heartland based component, disregarding ''Your Right to Choose''.

Please join us for an informative meeting:

Who: The Coalition for Quality Healthcare
When: Tuesday, October 17 &/or Thursday, October 19
Where: Stan's Golden Grill
Time: 6:30

It is only necessary to attend one of these meetings. We wanted to create an option in an effort to accommodate everyone's busy schedule. We will make every attempt to contain these meetings to approximately 1½ hours.

RSVP your attendance today to: 279–5393.

Our goal is to submit to the United States District Court for the Western District of Missouri our recommendations to amend the ''Final Judgment''. We as a group of professional healthcare providers and concerned citizens, *must* take this stand now, or abide by the decree that will be enforced as of November 13, 1995. Together, we *CAN* make a difference.

Questions? Call 279–5393.

Sincerely,
The Coalition for Quality Healthcare

Citadel Health Care

5026 Faraon Street, St. Joseph, MO 64506, (816) 279–1591, Fax (816) 232–3775

October 3, 1995.

Gail Kursh,
Chief, Professions & Intellectual Property Section, Health Care Task Force, Department of Justice, Antitrust Division, 600 E Street, Room 9300, Washington, D.C. 20530

Dear Ms. Kursh: We are a small 100-bed skilled nursing home sitting in the shadows of Heartland Hospital of St. Joseph, Missouri. By doing a good job in all respects, we have been able to survive. But being a neighbor to an octopus, when the octopus is trying to eat you every day, is no fun.

The ''Final Judgement'' filed with the district court falls far short of creating a level playing field. Heartland conducted an elaborate building campaign and vastly expanded it's new ''campus'', then had it's older facility left mostly vacant. Being good business persons, they chose to convert that hospital structure into a skilled nursing home, directly affecting 400 other long term care beds operated by private entities. Heartland's intrusion into the market added a 50% increase in nursing home beds in a state where a certificate of need is/was required, except that they used political influence to circumvent the certificate of need laws to be our monster competitor.

Does Heartland refer persons to our nursing home? Fat chance! They raid our census every time we have someone that becomes ill enough to need hospital or rehabilitation treatments. If those residents leave us, and they either have Medicare available coverage, or have private insurance, or are lucky enough to be financially secure, they never come back to us. They or their families are ''sold the Heartland philosophy'' (that Heartland can do more than any other nursing home, and do it so much better that nobody should ever leave Heartland's sphere of care). We have four such cases just in the month of September 1995, and know that those people will not be back until they are indigent, at which time Heartland will dump them like the next load of garbage, back to a nursing home.

Or if the person makes significant recovery, Heartland refers everyone possible to it's wholly owned ''Heartland Home Health Care'', which looks like it is just about to force all three other home-care businesses out of business. This seems grossly unfair, considering that again Heartland is the ''new kid on the block''. The other home care agencies were in business long before Heartland entered that market.

Is it coincidence that Heartland is thriving and all other health care businesses in the area are struggling for survival? Not hardly. Heartland has already bought approximately 80% of all the available physician services in the area. And if the doctor wants to keep his job (not his practice—just his job), he will do as Heartland directs.

In the long term care industry, survival depends upon a facility's relationship between local physicians and the hospital. Where does that leave every long term care provider in St. Joseph? Answer: 1) Competing for patients with the hospital; 2) Depending upon referrals by doctors that are employees of Heartland, operating medical practices that are owned by Heartland. If a potential nursing home admission is first seen at the hospital, if there is room in Heartland's facility and there is a way to induce the family to stay there, that is what happens. If the potential admission is seen in one of Heartland's medical practices (and they own approx. 80% of all the providers in the area), the Heartland provider is certainly referring potential clients to Heartland's nursing center.

If when the managed care capitation occurs, Heartland will now be in a position to absolutely bankrupt all the other nursing facilities in the area because they have a large, former hospital to expand into. They can bid services below their competitor's cost of staying in business because of their competitive advantage * * * an advantage based upon monopolistic principles of eliminating competition.

It is relevant to note that Heartland's per diem rate is approximately 25% higher than other competitive nursing homes here, they are 95% filled with private paying residents, and the composite private pay census of all other homes in this area is approximately 25%. Heartland has staff persons whose responsibility is to recruit from the hospital to fill their nursing home with private paying persons. Nobody else in this area has access to walk the halls of the hospitals to recruit persons in need, and have the ''closed market'' already captured.

We know that Heartland has spent huge sums of money defending its right to acquire and operate all of the health care industry in a large area of northwest Missouri. Unless something is done in the near term future, they will squeeze their smaller counterparts like a huge python kills its prey. And when there is no life left, Heartland will swallow the remains.

When the competition is gone, so will be all ability to make independent health care choices, and so will go the availability of services to the masses. Heartland is flourishing because it already has captured the private pay market that can and does pay market rates. The rest of us must accept public assistance patients, or not accept any at all. Heartland gets all the private pay clientele, not because they necessarily provide better product, but because it's hospital has first access to those folks. If they were not sold a ''bill of goods'', why else would someone opt to pay 25% premium for services in a hospital-converted nursing home when they could have a much homier accommodation in some of this city's nursing facilities? Unfair competitive advantage!

Please do not turn your backs on the providers that took care of this community before Heartland became a megopoly. Those providers all survived and provided good service until the hospital pushed them aside. Given any kind of equal opportunity access patients, those facilities can still compete. It is the lack of access, due to Heartland's vertical integration, that threatens the livelihood of the other health care businesses in this area.

Thanking you in advance for any assistance you may provide, I remain.

Sincerely,

Lowel Fox,

Administrator.

October 11, 1995.

Ms. Gail Kirch
Health Care Task Force, U.S. Dept. of Justice, 600 E St., NW., Room 9300, Washington, DC 20530

Dear Ms. Kirch: Regarding Heartland Health System and St. Joseph Physicians Inc. in St. Joseph, MO. I prefer to go the a *doctor* of *my choice* and a *hospital* of *my choice.* I have gone out of St. Joseph for years and hope to continue to do so.

Heartland Health, under Lowell Kruse, has been attempting to ''keep everyone in the area'' for years. There needs to be a full scale investigation.

Sincerely,

Evelyn W. Nask,

2720 Francis, St. Joseph, MO 64501.

October 8, 1995.

Dear Ms. Kursch, Chief, Professions & Intellectual Health Care Task Force: I wish to comment on your proposed consent decree concerning Heartland, Health Choice and St. Joseph Physicians Inc. in St. Joseph.

It is *not* my desire to have *my* choice of doctor(s) and hospital eliminated. If I choose to go outside Heartland Health System for medical treatment I want that to be a viable option for me.

It appears Mr. Lowell Kruse and Heartland Health System are attempting to create a monopoly in N.W. Missouri, thereby running competitors out of business.

There needs to be a large scale investigation (without warning) of this entire system. I also think the doctor should be in charge of the patient, not the administrator on the insurance company.

Sincerely,

Ruth Serrells,

2730 Felix St., St. Joseph, MO 64501.

cc:

State of Missouri, Attorney General's Office, Attn: Mr. Gary Kraus, Superior Court, Box 899, Jefferson City, MO 65102

November 4, 1995.

Gail Kursh,

Chief, Professions and Intellectual Property Section Health Care Task Force, Department of Justice, Antitrust Division, 600 E Street NW., Rm. 9300, Washington, DC 20530

Dear Ms. Kursh: This is an explanation of how I feel Heartland's policy and competition has affected my business over the last few years and how it will affect me in the future if strict guidelines are not put into place.

Heartland is competing with me directly for my nursing home patients and for my regular customers as though they were a standard business competing for profits. Competition is good and will always be the best system to keep all of the business community on the leading edge of giving the patients the best quality care they can possibly receive. As a ''for profit'' business, I must pay taxes and incur expenses in the day-to-day activities that control how I do business. Heartland, on the other hand, is competing directly for my patients and other laboratory, home health, and hospice care, etc. that they want to control, on a non-profit basis * * * How is that possible? Their desires and efforts are towards controlling all aspects of healthcare in the entire Northwest Missouri area.

My business has decreased two-fold in the nursing home area. One is in direct competition for my customers in the homes and secondly through Heartland's in-house referral policy. When a patient is admitted into Heartland Hospital from a nursing home, they are ''captured'' into Heartland's system. When these patients are discharged, they are, on many occasions, discharged into Heartland's skilled or intermediate care facility and are then serviced by Heartland's own pharmacy. As you research past history you will see Heartland has already been in trouble for not giving their patients a real choice in their Heartland Centre facility. As a matter of fact, Heartland used to make their long-term care center patients sign a statement that they would only get their pharmaceuticals through the Heartland pharmacy. It has only been recently, (within the last two or three years) that Heartland was forced by Medicare to allow other pharmacies into their nursing home setting. At that time, Heartland officials sent a letter to their patients which lead the patient and families to believe that if they didn't use Heartland's own pharmacy, Heartland could not guarantee the quality of service they would receive. This is a very scary thought to these elderly patients and their families. It is also a statement that could not be further from the truth. Given this ''threat'', does the patient really have a choice in pharmacy?

My total prescription volume, down by 20% in the last two years, is partially due to Heartland's policy to discount their prescription ''copay'' to all their employees for the purpose of increasing the volume of their new pharmacy. Even if we could afford to do this (reimbursement for our services by the Heartland HMO does not leave room for any more discounts) our contract with the claims processor makes discounts an unfair business practice. It should also be noted that Heartland, because of their position as a hospital and now an HMO, receive deep discounts on prescription drugs. Sometimes Heartland may pay as much as 80% less for the same pharmaceuticals that I buy at wholesale prices. This constitutes another aspect of unfair competition. There is no way I can cut my prices to adequately compete when I have to pay so much more for the same items. Several years ago Heartland had another pharmacy which tried to compete with existing pharmacies and could not make it on standard competition. Needless to say, Heartland has found this ''unfair'' competition much more lucrative.

Jake's also does not receive any referrals of patients as they leave the hospital and have needs for walkers, canes, crutches, wheelchairs, commodes and numerous other healthcare necessities for recuperation at home. This is an area I know all to well. I used to own a business that worked exclusively in home care supplies and fell to Heartland's unfair and unprofessional business practices. After building a quality business, having a past, non-exclusive, service contract with Heartland, and a letter of intent for continuation of this contract along with increased equipment needs forcing a large expenditure on my part, Heartland began doing business with another company without notice. This forced me into a sale situation which was less than desirable.

My major concern is for the patient's overall healthcare. Competition is what keeps hospitals, pharmacies, hospices, and other healthcare services accountable to the general public and each individual consumer. Competition encourages business to be the best that it can be. St. Joseph has only one hospital. The public is not able to compare Heartland's services to another hospital and choose the one which best provides for their specific needs. The new Heartland HMO seals the fate of true competition, not allowing for any choice what-so-ever in hospital services. If competition is further impeded, if Heartland is allowed to go forward with their plans without strict checks and balances, who benefits except the pocketbook of Heartland? If these other services, represented by many companies, are allowed to fall by the wayside, who will be able to hold Heartland accountable? What guarantees will be in place that will make sure the patient's welfare and comfort are the driving force of healthcare decisions? I am deeply concerned that without the variety of businesses now involved in the many areas of healthcare in the St. Joseph community, Heartland will have a ''captive audience''. It will not make decisions based on what is best for the patient, but will judge a patient's healthcare treatment by money saved * * * by profit generated.

You have the power to ensure that fair competition exists in the St. Joseph community. It is within your power to ensure that Heartland's domain is not allowed to continue to snowball and over-run its competitors. Unfortunately, if nothing is done to strictly control Heartland, by the time it is realized that lack of competition breeds apathy and poor service, the competitors will be gone.

In closing, I want to thank you for the opportunity to speak to these issues. I hope you are able to see the crisis faced by myself and my colleagues. If I can be of further assistance, please feel free to contact me at the address and phone number listed below.

Sincerely,

Richard C. Bosworth,

Coalition of Quality Health Care, 2318 N Belt Hwy., St. Joseph, MO 64506.

Armstrong, Teasdale, Schlafly & Davis

Attorneys and Counselors

1700 City Center Square, 1100 Main Street, Kansas City, Missouri 64105, (816) 221–3420, Fax (816) 221–0786

November 13, 1995.

Edward D. Eliasberg, Jr.,

Antitrust Division, U.S. Dept. of Justice, 600 E. Street, N.W., Room 9420, BICN Bldg., Washington, D.C. 20530

Re: U.S. v. Health Choice of Northwest Missouri, et al., Civil Action No. 95–6171–CV–SJ–6, Pending in U.S. District Court, Western District of Missouri

Dear Mr. Eliasberg: This office represents The Coalition for Quality Healthcare, a Missouri non-profit corporation made up of businesses in the St. Joseph and northwest Missouri area who provide ancillary healthcare services to the public. In connection with our representation, we are preparing to respond to the proposed Final Judgment in the above matter.

We obtained a copy of the proposed Final Judgment (consent decree), Stipulation, Complaint and Competitive Impact Statement from the district court. We were informed by the district court that no ''determinative'' materials or documents called for by § 16(d) of the Tunney Act were filed with the court. We also called your Department to request those documents or materials and were told that none exist in this case.

Section VII of the filed Competitive Impact Statement recites that ''No materials and documents of the type described in Section 2(b) of the APPA, 15 U.S.C. § 16(b), were considered in formulating the proposed Final Judgment.'' In light of the fact that this suit

resulted from a multi-year investigation by your Department, during which administrative depositions were taken and documents produced by defendants, it seems improbable under the circumstances that no documents exist which your office considered determinative in drafting the proposed consent decree.

This very issue was taken up by the district court in *United States* v. *Central Contracting Co., Inc.,* 537 F.Supp. 571 (1982). In *Central Contracting,* in response to a request for materials called for by the Tunney Act, the Department of Justice asserted that ''there were simply no documents or materials * * * that contributed materially to the formulation of the proposed relief.'' *Id.* at 573. The Court found the government's assertion disingenuous in light of the government's similar claims in 172 out of 188 prior cases that it considered neither documents nor any materials determinative. *Id.* at 577. The Court refused to blandly (and blindly) accept the government's certification that no documents or materials led to the government's determination that it should enter into a consent decree. *Id.* at 575. Rather, the Tunney Act required a ''good faith review of all pertinent documents and materials and a disclosure'' of those materials called for by the Act. *Id.* at 577.

We hereby request on behalf of The Coalition for Quality Healthcare that the United States produce to this office and file with the U.S. District Court for the Western District of Missouri a list of any materials and documents which the United States considered ''determinative'' in formulating the proposed Final Judgment, so that we or any members of the public may request copies of specific documents from your Department.

I look forward to your prompt response to this request.

Very truly yours,

Thomas M. Bradshaw, P.C.

TMB:kag

cc: Ms. Kristin Helsel, President, Coalition for Quality Healthcare
Glenn Davis, Esq.

Heritage Home Health

Central Office: 169 Daniel Webster Hwy., Suite 7, Meredith, NH 03253, 603–279–4700, Fax 279–1370

Branch Office: 500 Commercial St., Unit 302B, Manchester, NH 03101, 603–669–5700, Fax 669–5755

November 14, 1995.

Gail Kursh,
Chief, Professions & Intellectual Property Section/Health Care Task Force, Department of Justice, Antitrust Division, 600 E Street, NW, Room 9300, Washington, DC 20530

Re: DOJ's recommended home health, DME and hospice referral policy for Heartland Hospital

Dear Chief Kursh: I read with interest an article that appeared in . . . *home health line,* November 13, 1995, Vol. XX, No. 43, that referenced the above mentioned policy. Please take a moment to consider the following:

(1) The main source of referrals for home health services come from hospitals. The vast majority of consumers of home health services are patients discharged from hospitals in need of follow-up care.

(2) Free standing home health agencies can not reasonably duplicate such a facility (hospital).

(3) Free standing Medicare certified home health agencies are inspected according to the same federal regulations as hospital based home health agencies. There are no requirements or need for further ''independent review or evaluation'' by the hospital.

(4) Vertical integration and monopolizing of referrals can and will not serve long term cost containment.

(5) Medicare beneficiaries should be offered a list of all participating Medicare providers when they are in need of services.

(6) Hospitals should have discharge planners that are not affiliated with any home health agency, including the hospital based home health agency. Referrals could then be made to the best provider for the given circumstances. Often times, even though the hospital based agency can not properly service a patient, the referral is given to them, only to have the patient left without service entirely or on their own to locate another provider. Hospitals are reimbursed for offering discharge planing to their patients to locate the best possible scenario of services for that patient and to ensure that persons' discharge is a safe and successful one. In the current environment, however, discharge planners are fast becoming ''casefinders'' for Hospital based home health agencies.

(7) Hospital discharge planners often refer patients to other types of Ancillary services, that they are not affiliated with, when the hospital does not own facilities or agencies offering that type of service without doing an independent review or evaluation. For example, a referral to a skilled nursing, sub acute of rehabilitation facility.

(8) Hospitals are no longer the community providers they once were. They take the homes of people who owe them money. They employ attorneys, accountants, MBA's, image consultants and more. They advertise. Health care is a business. Hospitals are profiting from that business. They should not be allowed to continue unchecked.

Thank you for your consideration.

Sincerely,

Carolyn A. Virtue,

Administrator.

MS&R—Medical Sales & Rentals

1411 Memorial, Bryan, Texas 77802, (409) 776–5555

November 14, 1995.

Gail Kursh,
Chief, Professions & Intellectual Property Section/Health Care Task Force, Department of Justice, Antitrust Division, 600 E. Street, N.W. Room 9300, Washington, DC 20530

Re: United States v. Health Choice of Northwest Missouri, Inc., et al., Case No. 95–6171–CV–SJ–6

The Coalition for Quality Healthcare is correct. Heartland Hospital is taking away a person's freedom of choice. Allowing the hospital to eliminate competition will eventually lead to poor service and poor quality of care. The independent businessman is the backbone of this country and that will be eliminated if the hospital is allowed to keep referring their patients to themselves.

Your recommended referral policy for Heartland Hospital is not correct. It is ''big business'' orientated and does not consider the patient or the independent businessman.

A local hospital opened their own DME company last year. Since that time two independent companies have had to change their day to day business strategies because they no longer get referrals from the area's major hospital. We are fighting to stay in business.

Please call me at 409–776–5555 if you would like more opinions or viewpoints.

Sincerely,

Nathan L. Cook,

Owner/President.

HealthCare Personnel

Moorings Professional Building, Suite 407, 2335 Tamiami Trail No., Naples, FL 33940, (941) 261–8700 FAX (941) 261–7206

November 15, 1995.

Gail Kursh,
Chief, Professions & Intellectual Property Section, Health Care Task Force, Department of Justice, AntiTrust Division, 600 E St., N.W. Room 9300, Washington, D.C. 20530

Re: United States v. Health Choice of Northwest Missouri, Inc., et. al. Case No. 95–6171–CV–SJ–6

Dear Ms. Kursh: The proposed final judgment for U.S. v. Health Choice is a death knell for quality care in the home health care setting. Competition supports and promotes a high quality of care, evidenced by clinical outcomes, cost-effective clinical guidelines, patient satisfaction and appropriate utilization of community resources. Your proposed judgment creates a monopoly for hospital-based home health care agencies and the end of competition in home health care.

Hospitals have a ''captured audience'' of vulnerable patients who feel dependent upon the hospital staff. Patients are not likely to defy a discharge planner's referral to the hospital home health agency for fear that their defiance would create an environment where the patient's continuing needs (in-patient needs and paperwork for reimbursement needs) may not be met or may be delayed.

Additionally, hospitals exert their influence over physicians (with hospital privileges) to refer only to the hospital-based agency in order to support the hospital. Some hospitals have even moved their home health agency from being a separate entity to a hospital department, so that self-referrals are not subject to GAO investigations instituted by Rep. Pete Stark (D-Calif.). A second reason may be to shift administrative costs.

I have been in home health agency administration for twenty years. In the past two years I have seen hospitals discontinue

a referral rotation system, discontinue hospital access to patients by agencies who serve them, refer only to their own agency, call physicians to ask why a hospital patient was referred to an outside agency, and hide all referral data and percentage of referrals to hospital based or outside agencies. All these practices reinforce a hospital-based home health care monopoly.

Hospital arguments for promoting their own agency at the exclusion of outside agencies include continuum of care, referrals to other agencies would require hospital credentialing of outside agencies, and hospitals always give the patient a choice. It is easy to refute these claims.

The traditional continuum of care has always been from organization to organization, be it a hospital or other community resource agency, with patient information transferred between professionals who are trained to focus on continuity and coordination of care. Just because a home health agency has the same name or is affiliated with a hospital does not, in itself, assure quality, continuity or coordination of care. Continuum of care actually is a reimbursement train for the hospital, in the absence of their desired hospital-based reimbursement bundling.

The responsibility of a discharge planner includes knowledge and judgment regarding all home health care community resources that would benefit the patient. Traditionally, in cities as large as Cleveland, Ohio and as small as Naples, Florida, discharge planners have always known resources available, and have received feedback regarding the quality of care from those agencies. Besides, state home health agency licensure laws establish standards that agencies must meet, so hospitals should know that standards are met and don't need to ''credential'' them.

Finally, hospitals ALWAYS state they give the patient a choice, yet many outside agency patients have told outside agencies that during their hospitalization, hospital representatives have almost insisted they use the hospital-based agency and demand to know why the patient would NOT want to use an affiliated agency. Also, physicians who refer to outside agencies tell outside agencies that as soon as the patient is admitted, before the physician even discusses discharge with the patient (to advise them of the physician's choice of agency), the hospital-based agency has already been in to talk with the patient and already has them signed up as a referral for their agency. The physician does not even have a choice.

Thank you for the opportunity to send you my comments on your proposed final judgment for the above mentioned case. Please don't be persuaded by big hospital corporations and hospital lobbyists to pass a judgment that abolishes competition in home health care and effectively gives patients no choice and no recourse when a complete monopoly occurs.

Sincerely,

Greg Eggland,

Director.

Health Personnel Incorporated

1110 Chartiers Avenue, McKees Rocks, PA 15136–3642, (412) 331–1042, FAX: (412) 331–2774

November 16, 1995.

Gail Kursh,

Chief, Professions & Intellectual Property Section/Health Care Task Force, Department of Justice, Antitrust Division, 600 E. St., N.W., Room 9300, Washington, D.C. 20530

Dear Chief Kursh: After reading the article that appeared in the 11/13/95 edition of *Home Health Line* I feel it is necessary as a free standing home health care agency to comment on the Department of Justice's proposed referral policy for Heartland Hospital. This policy will be precedent setting for all hospitals across the nation and fails to take into consideration a number of things such as:

The main source of home health referrals is hospitals and hospitals have a captive referral source which cannot be duplicated in any other way. Yet, they are a very expensive source of home health care and often provide a poorer quality of care. Hospitals pass through some of their administrative and general costs to their home health agencies and get away with this ''double dipping''. The cost of a visit is increased by passing through costs of the hospital and this does not help cost containment efforts.

Also, at least in this area of the country, hospitals do not individualize their care. They discharge patients from homecare before they stabilize which sends them back to the hospital and increases health care cost.

One way to stop this is to enforce regulations: Freestanding agencies must meet the same certification and/or licensure standards as hospital agencies. Therefore, hospitals should have a rotating list which assures equitable referrals to all qualified providers (one that meet Medicare certification (licensure) standards and have the necessary services). The hospital should have to make their percentage of referrals public knowledge to each agency.

The discharge planner should offer a list of all participating Medicare providers in the service area and the discharge planner should have no affiliation with any agency. By the way, hospitals often cannot service the patient adequately and so the patient is left without care, i.e. a physical therapist is not available to see the patient in a timely manner (four weeks later a physical therapist is starting to see the patient). No home health aide is available so the hospital agency tells the patient that they do not qualify for a home health aide. (For example, the patient has a fractured arm and myocardial infarction but, does not qualify for an aide?)

Although, your policy puts the physician back in control, it fails to take into consideration the fact that here in Pittsburgh, if doctors refer to another entity outside the hospital, the hospital can revoke their privileges. (This is happening in Pittsburgh.) You need to write the settlement so that hospitals cannot retaliate or put pressure on the doctor to refer to their agency.

Referring the patient to the phone book is inappropriate as the patient cannot tell which providers can give the kind of care they need or who is Medicare certified. Also, the list of other providers needs to be written as sick or well people, cannot remember many, if any, names and they need the phone numbers.

This issue covers more than the antitrust issue you seem to be addressing. The settlement fails to address the Anti-kickback Law which prohibits hospital doctors (doctors paid by the hospital) from referring to a hospital owned agency and the Stark II Law. According to these laws, no agency can receive referrals from any physician who has been paid more than $24,999.00 by that agency. If a hospital or doctor owns more than a 5% financial interest in an agency, they cannot self refer.

Health Personnel, Inc. has tried to address these issues with HCFA since 1986 and no one has been able to resolve these problems. In addition, the American Federation of Home Health Agencies has had discussions with Mr. Thomas Hoyer at HCFA in Baltimore regarding the patient choice issue. I hope you will resolve these problems and legal questions.

Sincerely,

Phyllis W. Fredland,

Director of Nursing.

Home Health Specialists

November 16, 1995.

Gail Kursh,

Chief, Professions & Intellectual Property Section, Health Care Task Force, Dept. of Justice, Antitrust Div., Washington, D.C. 20530

Dear Ms. Kursh: I have recently read the D.O.J., proposed referral policy for home health, DME and hospice for Heartland Hospital. I personally find this totally absurb. If this proposal passes it not only will affect the freestanding home health industry, but will also affect a patient's right to choose, even though the bill offers some small reference to freedom of choice. The government reports that Medicare will be broke by the year 2007, and then a bill such as this is recommended for hospital based agencies. Evidently there has been no investigation of the cost of hospital based agencies versus freestanding agencies for patient care and supply reimbursement. To allow a hospital to elaborate on their agency and state that they know nothing of the other agencies in town is absurb, when we all know that being a discharge planner, they have had some dealings with the other agencies in their area. Freestanding agencies have received a bad deal, since the beginning of hospital agencies when it comes to referrals and this will only make it worse. We provide the same quality and conservative care that they state they provide and at a lower cost. As it stands right now in our area, we are not allowed to place brochures in our hospital, visit our former patients, because that is considered solicitation by the hospital, and we are not allowed to view the admittance and discharge rooster. This only

started when they opened there own agency. A rotation of referrals would give everyone a fair chance to provide the care for the patients that we should all strive for. This would stop the hospitals attempting to monopolize the health care industry and could possibly reduce the legal and judicial fees that are being used due to law suits over the monopolizing of care. The posting of referrals would then allow the freestanding agencies to view how referrals are given and provide some insight into the qualifications and professionalism of the discharge planners, who in some instances are placed in the hospitals by competing home health agencies. If the bill is passed as the D.O.J. recommends, you will see slowly the fading away of freestanding home health companies the provide a large number of jobs to people in our area. I hope that the people reviewing this proposed policy really know the impact that this will have on the health care industry and take into consideration that it is hard enough now for freestanding agencies to receive referrals from hospitals, knowing fully well the discharge planners are not playing by the regulations that are in existence now, and this would make it easier to violate regulations, while at the same time allowing an industry of freestanding ag to die away. Please, for all the freestanding agencies that are in existence please review this referral policy closely and make discharge planners to rotate referrals as well as make available to home health agencies the list of the referral list.

Sincerely,

Donna Isabell,

Administrator/President, Home Health Specialists, Inc.

November 6, 1995.

Dear Gail: My name is Kathy Smith. I read an article in the St. Joe newspaper on Sept. 24, '95 concerning Heartland Health System. This article really hit home with me. This hospital, or so called hospital, has ruined my life. Let me tell you my story.

I broke my ankle on April 12th of this year. I was taken to the hospital by some friends. (My husband works the late shift so he met us at the hospital later.) I waited in the emergency room for one hour and 45 minutes. In that time, no one came out to check on me. I finally had my husband go ask a nurse for a blanket. My body was beginning to shake. I imagine shock was starting to set in.

Finally I get back to E.R. and am taken on to X-ray and I wait some more for a doctor to come and set my foot. I find out I need surgery. They will do it tomorrow (April 13). I leave E.R., its after 2:00 in the morning.

Surgery is done the next afternoon. All went well, or so I am told. I get released on the 14th & I go home.

Now, you have to understand, I'm 33 years old, and am married and have two small boys, ages 3 and 5. I'm walking or hoppling around with a walker, can't fix supper, can't do all the chores around the house, that I used too. This hurts, I've never had to depend on other people. But I figured, I'll be up and around in 6 to 8 weeks, just like the doctor had stated. End of story? I wish, it's only the beginning!

One week after the 1st surgery in April, I came down with a high fever of 103 degrees, then the chills, and nausea. I called my doctor, he wasn't in. I told the nurse, or the secretary or whoever, and they said they would get a hold of him and have him call me. He did, about 45 minutes later. I told him all the symptoms, and do you know what he said, I must be coming down with a cold or maybe the flu. Take some Tylenol.

I went back to the doctor, every week for the next month, then every 2 weeks for awhile. I had a place on my ankle that wasn't healing. He (the doctor) would squeeze on my leg and say that was fat draining out. He even brought in a colleague, and they both agreed that was what it was. (No not once in his office did he wear rubber gloves when he touched my ankle (leg).)

Finally after about a month, he decided to put me on antibiotics (actually he gave me a choice, go in the hospital or take antibiotics.) Now, when you have a family that depends on you, what choice if any would you have taken? So I took antibiotics. Even when I went back to see this doctor (on antibiotics) he'd continue to squeeze on my leg, and it (puss) would just ooze out and one time he mentioned, maybe it is a blood clot.

We are in June now, the 5th. He decides he'd better go in and take the plate and screws out. It's June 7th, he took the hardware out. The infection had eaten my flesh away, and some bone along with it. Actually it had spread into my bone. Now I have osteomyelitis (a bone disease). I thought I was going to lose my whole foot & part of my leg! Where did they get this doctor from? I had a lot of unanswered questions? I was worried, I was in pain and I was scared.

Two days later, I got another visit from another doctor he wants to put a groshong catheter in my chest. Why? I ask. I needed to be on vancomycin (one of the strongest antibiotics used to control osteomyelitis.) I have that surgery on June 9th. The doctor assured me I wouldn't feel a thing. I was to be given a local to deaden my chest area. Well, the local didn't work. I was awake through ¾ of the operation talking with the doctor & the nurses. Have you ever heard of a doctor going through with an operation when the patient was awake? I could feel those tubes running down to my heart. It did hurt but I tried to be strong & not let the pain get to me too bad.

The first doctor, he called in a plastic surgeon. He was to try to fill in this hole in my leg (that hole was left by the first doctor after he took plate & screws out, where the flesh had rotted away.) So the plastic surgeon, cut a flap in the back of my leg to fill in the original hole. It was done on June 13th. Then I laid in the hospital bed for a week and couldn't move. The 3rd doctor said let's keep our fingers crossed to make sure this takes (skin graft).

Also the 3rd doctor said to me ''if I were in your shoes, or one of my family members, I wouldn't be real upset with doctor #1.'' Can you believe what he told me? I came so close to losing my foot and he had the nerve to say something so foolish!

On June 20th, the gal from the Heartland Home Health Care came in and said, ''We've got you all signed up for H.H.C.'' I wanted to know why and she said ''because you'll have a nurse come over & make sure you get the vancomycin twice daily.'' The nurse from H.H.C. told me it was kinda expensive. They had contacted my insurance co. and they agreed to pay 80%. We had to pick up the 20%. I thought it (the price) couldn't be real bad. But I was wrong. Each bag of medicine was $65.00. Thats $130.00 a day. I was on this medicine from June 21st to August 24th. The nurse came out almost weekly to draw blood for tests. The 1st doctor told me I wouldn't be on it (vanco) for long. He was wrong. I was dismissed from hospital June 21st.

There was no mention I could have gotten another Home Health Care Provider, in fact I was shocked to learn, other ones were out there, & that they may have been cheaper. I guess you could call me stupid, but after this nightmare, I have really opened my eyes. Each visit with a nurse was over $100.00.

These people must think we are made of money. My husband is a welder, at a plant here in town, and he doesn't make alot of money for 4 people to live on. We rent the house we live & our fortunate to have 2nd hand vehicles to drive. Our kids get hand me down clothes.

So you see we don't have a lot of money, and Heartland doesn't help when they have such high prices for their services, and they need to stop monopolizing the St. Joe area.

By the way, my 1st doctor told me after I asked him a few times. (''I had picked up the stupid infection from the hospital from the surgery.'') Isn't that a kick in the ass? Now, we have all these hospital bills & doctor bills to pay. And I have a scarred up leg to show for it. And the doctors & hospital are getting richer for their mistakes. If you know anyone that could help me I would appreciate it!

Sincerely,

Kathy S. Smith.

October 17, 1995.

Gail Kursh,

Chief, Professions and Intellectual Property Section/Health Care Task Force, Anti-Trust Division, U.S. Department of Justice, 600 E St., NW., Room 9300, Washington, DC 20530

Re: Heartland Referral Policy—consent decree page 13B–1

As a prior patient of Heartland Hospital, choices in health care providers were not given at the time of discharge.

I believe upon being admitted to the hospital, information on all agencies should be provided to all patients.

Being advised to check the phone directory is not a logical solution.

Kathy S. Smith.

VIP Home Nursing & Rehabilitation Service, Inc.

51 Century Boulevard, Suite 308, Nashville, Tennessee 37214, (615) 883–9816, (800) 826–8998

November 17, 1995.

Gail Kursh,

Chief, Professions & Intellectual Property Section/Health Care Task, Dept. of Justice, Antitrust Division, 600 E. Street, N.W., Room 9300, Washington, DC 20503

Re: United States vs Health Care of Northwest Missouri, Inc. Case No.: 95–6171–CV–SJ–6

Chief Kursh: In response to the above case/proposal, I would like to put some light on this proposal as far as freestanding providers are concerned.

Here in Middle Tennessee we feel like the unwanted step-child as far as hospitals are concerned.

Approximately ninety percent of the hospitals, large and small, now have their own in-house home care service.

We are told by the discharge planners:

1. We rotate our patients to assure equitable referrals to all providers in the area.

This is hogwash! We have called on some hospitals in the Middle Tennessee area for over a year and still do not get patients from a good portion of them. Or, if we do get a patient, it is because the patient has requested VIP (which has been overridden before), or the patient may live in an outlying area where the hospital home health cannot service due to distance. (VIP has six offices covering 22 counties.)

2. We have been told point blank that unless the patient requests a certain home-health agency, they will automatically be placed with the hospital home health service.

3. We have seen instances where the hospitals are referring patients to their home health, without any input from the patient's physician. Sometimes the physicians get upset over this issue, because in some cases the hospital home health apparently doesn't provide the level of care that the physician would like to see.

4. Some of the smaller hospitals in the area have been in very poor financial condition. These have been bought out by another hospital that has an in-house home nursing service. The physicians in the area were so appreciative to be able to keep a hospital open in their area, that we have been told by the physicians that they will *only* use the hospital's in-house service because they feel so indebted to the new hospital.

5. Another hospital in this area was in the ''red'' and due to close in three to six months. A freestanding home nursing service contracted with them to run a home health service for them. The home nursing service, to my understanding, paid the hospital $3,000 a month to rent space (this is a very small town). The home nursing service has one of their own employees making rounds to the patients up for discharge, to check with them about their home health needs. The home nursing service is signing up patients left and right for their service. This is considered fraud under Medicare rules. Freestanding services are restricted by Medicare of direct solicitation of patients!

Do you see where our frustrations are coming from?

These in-house hospital home health services do not need to be given any additional power on referrals. They already have a captive patient population.

Passing this proposal would be a true slap-in-the-face for all freestanding providers of home nursing. Instead of a few crumbs, the step-children need a whole piece of the cake for a change!

Please help us!

Best regards,

Kay Smith,

Director of Patient Services.

November 17, 1995.

Ms. Gail Kursh,

Professions & Intellectual Property Section/Health Task Force, Dept. of Justice, Antitrust Division, 600 E. St., N.W., Room 9300, Washington, D.C. 20530

Re: United States v. Health Choice of Northwest Missouri, Inc., et al., Case No. 95–6171–CV–SJ–6

Dear Gail: My comments on the above case for hospital discharge planners are that the hospital should provide the patient with a list of area providers who handle that patient's needed service. The hospital should have the right to have their own service listed first, and give to the patient any material the hospital has prepared for that service organization.

The balance of the list should include, in alphabetical order, all other service providers who request to the hospital to be included on the list. The list should not encompass an area of more than 50 miles from the hospital. The hospital should be allowed to print a disclaimer that they cannot speak to the quality of care the other listed providers provide.

Thank you,

Michael W. Thomas,

4518 Forestwood Drive, Parma, Ohio 44134.

Our Lady of Mercy Medical Center

600 East 233rd Street, Bronx, New York 10466–2697, Phone: (718) 920–9000

November 16, 1995.

Gail Kursh,

Chief, Professions and Intellectual Property Section/Health Care Task Force, Department of Justice, Antitrust Division, 600 East Street; N.W., Room 9300, Washington, DC 20530

Re: Case # 95–61–71–CV–SJ–6, United States v. Health Choice of North West Missouri, Inc. et. al.

Dear Chief Kursh: I want to applaud your recommended Home Health, DME, and hospital referral policy for Heartland Hospital. It is appropriate that a hospital with their own home health agency refer patients to their own excellent, fully accredited agency.

Our agency does not keep statistics but we get frequent calls from patients when other agencies do not visit them within 24 hours of discharge from the Medical Center. It is hard to recommend other agencies!

Thank you for your support of the hospitals and their home health agencies.

Sincerely,

Rose M. Rosenberg,

DPS/Administrator, Home Health Agency, (718) 920–9030.

Hill Country Health Services, Inc., dba Hill Country Home Health

P.O. Box 909, Lampasas, Texas 76550, 512–556–8293, Fax 512–556–3591

November 20, 1995.

Gail Kursh,

Chief, Professions and Intellectual Property Section, Health Care Task Force, Dept. of Justice, Antitrust Division, 600 E. St. N.W., Room 9300, Washington, D.C. 20530

Re: United States vs Health Choice, Northwest Missouri, Inc., et al, Case No. 95–6171–CV–SJ–6, U.S. District Court, Western Division of Missouri

Dear Ms. Kursh: I would like to comment on the above case involving home health referrals from hospitals. As the owner/administrator of a free-standing home health agency in Central Texas, we deal with numerous hospitals and home health patients.

In our service areas, we have encountered hospital discharge planners participating in self dealing by referring predominately to hospital based home health agencies. The patients are told ''your doctor has ordered home health and we will have a nurse out to see you tomorrow.'' These patients are not given a choice of available agencies.

Many times, our former patients have requested our agency because of particular caregivers. They have been told by the discharge planner that these care givers do not work for us anymore, when in fact they do still work for us.

I believe in competition but it is really hard to compete against a monopoly.

In accordance to published Fraud Alerts (see attached), it is against the law to offer anything of value to induce a referral. If a hospital supervisor tells a discharge planner ''if you want to keep your job, you WILL refer patients to our (hospital based) home health agency'', then I feel this violates the intent and the letter of the law.

Your proposals in the aforementioned case falls far short of ''leveling the playing field''. I would like you to consider forcing hospitals to do the following:

a. Allow patients to exercise their right of freedom to choose their beneficiaries.

b. Allow non-hospital based providers to visit their former patients in the hospital.

c. Where no provider is specified by the physician or the patient, provide a list of eligible providers in the area so that a patient can exercise their right to choose their provider.

d. Make sure that discharge planners are not coerced by supervisors to violate Medicare Antitrust, and the Federal Trade Commission's laws by doing self referrals in order to keep their jobs.

Thank you for your attention to this matter and I trust that the Justice Department will rule in favor of all; the patients and those of us that compete on the currently unlevel playing field.

Sincerely,

Ron Julian,

Administrator.

Dennis O. Davidson, M.D.

A Member of Arkansas Family Care Network, Arkansas Physician Management, Inc.

2000 Harrison St., Suite D, Batesville, AR 72501

Mailing Address: P.O. Drawer G, Batesville, AR 72503

November 19, 1995.

Gail Kursh,

Chief, Professional & Intellectual Property Section/Health Care Task Force, Department of Justice, Antitrust Division, 600 E. St., N.W., Room 9300, Washington, D.C. 20530

Re: U.S. vs Health Choice of Northwest Missouri, Inc., et al, Case No. 95–6171–CV–SJ–6 in the U.S. District Court for the Western District of Missouri.

Dear Ms. Kursh: I am enclosing a copy of an article from Home Health Line dated 11–13–95 pursuant to the above captioned case. Please know at first that I own no interest in a Home Health Care Agency. The DOJ has made an error. In short, you have given the hospital the monopolistic power to slant probably near 100% of their referrals to their home health agencies. Discharge planners in the hospital are people hired by the hospital. Who but the hospital will they recommend referral to. You are not giving any equal accessibility to the patient's to other home health agencies. Hospitals also work out various deals with physicians and these physicians are eager to send all of their patient's to the hospital home health agencies anyway.

This decision is so unreasonable and stinks so badly that I am sending copies of this letter and article to all my senators and congressmen. I hope that they have the good insight to bring up some sort of law that puts a stop to a decision of this caliber. I cannot for the life of me understand that you can feel that there is any equity or justice in this decision.

Thank you for the opportunity for presenting my written comment.

Sincerely yours,

Dennis O. Davidson,

DOD/bjr.

cc:
Senator Dale Bumpers
Senator David Pryor
Senator Steve Bell
Congresswoman Blanche Lambert

Alternacare Home Health Services, Inc.

414 E. Main St., P.O. Box 2591, Lancaster, OH 43130–5591, (614) 653–2224, (614) 653–1333 FAX

November 21, 1995.

Gail Kursh,

Chief, Professions & Intellectual Property Section/Health Dare Task Force, Department of Justice, Antitrust Division, 600 E. St. NW, Room 9300, Washington, D.C. 20530

Dear Ms. Kursh: I would like take the opportunity to share my viewpoint regarding the case United States vs. Health Choice of Northwest Missouri, Inc., et al. It has been my experience that hospitals do not present the home health choice available to patients who are being discharged from a hospital. The discharge planners at our local hospital inconsistently provide the written list of choices—but rather verbally inform the patient of a select few. (The local hospital has a home health agency.)

It is not the responsibility of the hospital to ''credential'' or endorse any agency. Rather, it *is* the patient's right to be made aware of choices and have those choices honored. The hospital can simply provide the facts, via a brochure from each agency, and allow the patient to make their selection.

This same unfair practice of referring to hospital-owned agencies/companies is also occurring in the Durable Medical Equipment area of services and providers.

The referral policy of Heartland Health Systems, Inc. (St. Joseph, MO) is unfair and should not be acceptable. In the recommended referral policy, the choice is made for the patient, unless they choose another option. Certainly it is clear that this is not in accordance with the regulations requiring patient choice. Instead, the patient should be provided with available services (again with printed brochure), then permitted to make a choice. If the patient than has no preference, then a system of rotating the referrals to the local agencies may be considered as equitable.

Please consider carefully before approving any policy for referrals as proposed by Heartland Hospital.

Sincerely,

Diane Flowers-Stuckey,

Director.

The Lee Visiting Nurse Association, Inc.

P.O. Box 415, Lee, Massachusetts 01238, Telephone (413) 243–1212, FAX (413) 243–4215

November 20, 1995.

Gail Kursh,

Chief, Professions & Intellectual Property Section/Health Care Task Force, Department of Justice, Antitrust Division, 600 E St., Room 9300, Washington, D.C. 20530

Re: U.S. v. Health Choice of Northwest Missouri, Inc., et al., Case No. 95–6171–CV–SJ–6 in the U.S. District Court for the Western District of Missouri

Dear Ms. Kursh: The referral policy recommended by the DOJ for Heartland Hospital is highly prejudicial. ''Choice'' is most certainly diluted and may be seen as a very subjective term when used by a hospital discharge planner with affiliation to a specific home care agency.

Having experience in this area, I can imagine a patient being given a ''choice'' of a particular agency which is in fact more of a recommendation, a directive, or a preference depending upon the approach of the discharge planner. Most patients lack knowledge in this area and tend to rely upon the advice of the discharge planner: It is unusual for a patient to state a specific choice. However, if a patient expresses uncertainty and then is directed to a phonebook to ''choose'', this seems less than supportive or helpful in any way. Hence, choice is not a ''choice,'' and is, instead, a sort of punitive arrangement whereby the discharge planner essentially denies the patient assistance in ''choosing.''

How perverse! Choice is a word loosely interpreted these days, but since when is self-referral considered a ''choice?'' Only the most savvy, assertive patient could navigate such a system. Antitrust is dead if this is how the courts elect to interpret the patient's right to choose.

Sincerely,

Paula Schutzmann,

Executive Director, Certified Case Manager.

Sun Management Services

61 Duke Street, PO Box 232, Northumberland, PA 17857, 99 South Cameron Street, Harrisburg, PA 17101, 1–800–577–5514

November 20, 1995.

Ms. Gail Kursh,

Chief, Professions and Intellectual Property Services, Health Care Task Force, Department of Justice, Antitrust Division, 600 E. Street, NW., Room 9300, Washington DC 20530

Re: United States Health Choice of Northwest Missouri, Inc., et al., Case Number: 95–6171–CV–SJ–6

Dear Ms. Kursh: It is with great concern that I read the proposed settlement as it related to the recommended home health, DME, and Hospice referral policy for Heartland Hospital.

The policy repeatedly stated that ''if the patient has a preference, that preference shall be honored.'' We believe, however, that the policy does nothing to ensure even a minimal level of knowledge by the patient.

This policy is the equivalent of asking a patient's permission for major surgery without providing any information regarding risks or outcomes.

Patients at a minimum should be informed of other providers and be provided equivalent marketing materials that are used by the hospital. Patients should be offered access to other provider's staff for the purpose of evaluating options.

The argument by Heartland's Attorney, Thomas Watkins, that ''there is no hospital in the world that is going to want to bless somebody else's home health agency when they cannot be responsible for care. We cannot be in the position of educating the patient—we don't have the information'' is ridiculous.

Other providers are more than happy to provide the hospital and the patient the information required to make an informed decision. Hospital Social Service Departments routinely provide information about community resources. To allow them to act differently in areas where the hospital has a vested financial interest is questionable ethics at best.

The recommended referral policy not only provides inadequate access to information ensuring a patient's ability to make an informed choice but also provides the

hospital opportunity to be discriminate in terms of what patient it chooses to serve.

It is common today for patients simply to say yes to home health referrals; allowing the hospital to self refer desirable patients and to farm out to other provides those they wish not to serve.

We believe that the recommend policy protects the hospital's vested investments at the expense of an informed patient choice and suggest appropriate revisions be required.

Sincerely,

Steven Richard,

Senior Advisor.

Armstrong, Teasdale, Schlafly & Davis

A Partnership Including Professional Corporations

Attorneys and Counselors

1700 City Center Square, 1100 Main Street, Kansas City, Missouri 64105, (816) 221–3420, Fax (816) 221–0786

November 21, 1995.

Via Federal Express

Ms. Gail Kursh, Esq.,
Chief, Professions and Intellectual Property Section, Health Care Task Force, Department of Justice, 600 E Street, NW., Room 9300, Washington, DC 20530

Re: Objections and Comments of the Coalition for Quality Healthcare to the Proposed Final Judgment pending in *United States* v. *Health Choice of Northwest Missouri, Inc., et al.,* Civil Action No. 95–6171–CV–SJ–6, Western District of Missouri, as published in the Federal Register, Tuesday, October 3, 1995

Dear Ms. Kursh: This law firm represents the Coalition for Quality Healthcare (the ''Coalition''), a nonprofit Missouri corporation organized to assure consumer access to timely and relevant information and to promote competitiveness in the healthcare field. This letter constitutes the formal Comment and objections of the Coalition to the proposed Final Judgment pending in the above-referenced matter.

By way of background, the Coalition is comprised of concerned citizens and providers of ancillary healthcare services in Northwest Missouri, including St. Joseph, Missouri and its surrounding areas. Members of the Coalition include owners of long-term care facilities, home health care agencies, pharmacies, medical equipment companies, and other service oriented businesses operating in the healthcare field.

The Coalition members firmly believe that the proposed Final Judgment is not in the best interest of the public primarily because the proposed Final Judgment contains a provision requiring Heartland Health System, Inc. (''Heartland'') physicians to follow the Heartland ''Referral Policy'' if a Patient needs ancillary services upon discharge from acute care. Comparison of the provisions of the proposed Final Judgment to the Complaint reveals the anomaly that the Complaint focuses exclusively on defendants' efforts to foreclose competition from other managed care plans in Buchanan County. Heartland's Referral Policy is not mentioned in the Complaint and seems to have been improvidently added to the proposed Final Judgment.

The proposed Heartland Referral Policy denies patients the right to make an informed choice among ancillary service providers in the Northwest Missouri area. Specifically, the Coalition urges the Department of Justice to remove the Heartland Referral Policy from the proposed Final Judgment for the following reasons:

A. The Referral Policy is not in the Public's interest because it prevents patients from making an informed choice regarding Ancillary Services:

* The proposed policy would allow the doctor to initially order that a particular ancillary service provider be used, rather than allow the patient to choose freely among any of the ancillary service providers in the Northwest Missouri area. Because Heartland employs or is otherwise associated with the majority of physicians with staff privileges at Heartland's hospital, doctors will routinely order Heartland ancillary service providers for the patient. Hospital patients requiring ancillary services are frequently elderly, in ill health and are unlikely to question, let alone contest, a doctor's order, or understand the basis for the recommendation.

* Even if the doctor does not designate a certain ancillary service provider, the patient is nonetheless steered to Heartland. Under the proposed policy, the patient is only informed that Heartland has excellent, fully accredited ancillary services available and then the patient is given a Heartland brochure. The patient is *not* informed about the availability of any competing ancillary service providers in the Northwest Missouri area.

* If the patient rejects Heartland's ancillary service providers, or specifically asks what other providers are available, the patient is *not* given the names of or any information about non-Heartland providers. Rather, the patient is told that Heartland cannot provide any information about or recommend any of the other ancillary service providers and the patient is then merely referred to the telephone book to look for other providers.

* As a result of the foregoing, the Consumer is denied timely and equal access to sufficient information on ancillary service options and quality to make an informed choice.

B. Heartland, through its Referral Policy, effectively monopolizes the ancillary services market within Heartland's geographic service region, resulting in antitrust injury to other ancillary service providers:

* Heartland, located in St. Joseph, Missouri, is the only acute care facility in Buchanan County. The closest comparable facility is North Kansas City Hospital, located in Clay County, Missouri, 60 miles south of St. Joseph.

* Patients from private (non-Heartland) long-term care facilities who are transferred to Heartland's hospital for acute care are not returned to the private facility upon discharge, even if the patient had been a long term resident of the private facility. Rather, the patients are transferred to either Heartland's skilled nursing facility, which charges a higher daily rate than comparable facilities in the community, or to Heartland's rehabilitation center. The patients are then kept in these Heartland care facilities until medicare days are exhausted. The patients are only returned to their former private facility if Heartland does not want them or if the patient's funds are depleted.

* Patients of private Home Health Care agencies experience similar exclusion from their prior provider. Patients who have been cared for by a non-Heartland home health care agency prior to being admitted to Heartland's hospital are not returned to that agency upon discharge. Instead, patients are being directed to Heartland's home health care unless the patient objects to the doctor's order or recommendation to use Heartland. Because patients are often elderly, infirm and forgetful, they do not know that they can object to a change in home health care providers and insist that their former agency resume care upon the patient's discharge.

* Heartland hospital staff do not give notice to a patient's prior ancillary service provider when that patient is to be discharged from the hospital. In some instances, prior providers report that their patients have been home for two to four days with no follow-up care by their home health care agency because the hospital failed to notify the former provider of the patient's discharge. This is grossly harmful to the patient and greatly affects the quality of the patient's care.

* Failure to give notice of a patient's discharge also prevents the prior ancillary service providers from taking part in discharge planning for their patients, thus preventing the providers from competing in the marketplace for the patient's business. Providers report having been specifically denied the opportunity to participate in discharge planning meetings for their patients.

* Owners of private long-term care facilities and home health care agencies uniformly report a significant loss in revenue and patient census since Heartland began its Referral Policy which effectively eliminates a patient's choice.

* An institutional pharmacy which serves 60 nursing homes in St. Joseph and the surrounding area has lost significant amounts of business due to the overall loss of private nursing home patients to the Heartland system. Heartland's own pharmacy services the needs of patients using Heartland's ancillary services.

C. The Heartland Referral Policy and the proposed Final Decree have no accountability provisions to ensure that Heartland Hospital patients, and patients of Heartland's physicians, are being given sufficient, unbiased information to allow the patient to make an informed choice among all available ancillary service providers.

D. Taken together, the foregoing considerations concerning the Heartland Referral Policy, Heartland's physician practice and recruitment efforts, and Heartland's other conduct create conditions that facilitate unlawful maintenance of monopoly power by Heartland through anticompetitive and coercive means,

conditions conducive to a successful attempt by Heartland to monopolize the ancillary services markets in Northwest Missouri and Northeastern Kansas, and conditions that permit Heartland to channel or steer patients in need of ancillary services only to providers it owns, controls, or in which it maintains a significant economic interest.

The antitrust concerns in this situation are clear, the most significant of which is foreclosure from referrals. The proposed Referral Policy will only exacerbate this situation and ultimately will result in an insufficient number of referrals for Heartland's competitors in ancillary services to remain viable. This, in turn, will increase Heartland's market power substantially and create the risk of enabling Heartland to raise and sustain prices above those which would otherwise prevail in a competitive marketplace, or lower the quality of care. Whether analyzed in terms of Heartland's efforts to engage in exclusive dealing agreements, tying arrangements, reciprocal dealing agreements or monopolization and attempted monopolization, via predatory refusals to deal, abuse of essential facilities, or monopoly leveraging, the anticompetitive effects, which are contrary to the public interest, are apparent.

The Coalition is currently drafting a model Referral Policy which allows patients to make an informed choice among all ancillary service providers in the St. Joseph and surrounding regions. We will provide the Department of Justice and the District Court with a copy of the model Referral Policy, along with arguments and authorities in support of its adoption, within the next 10 days.

While the ancillary services Referral Policy is of paramount importance to the Coalition, other terms and conditions of the Final Judgment give unfair competitive advantage to Heartland in the primary care physician market. The Coalition specifically objects to the following provisions in the Final Judgment:

A. Part VIII: Heartland Permitted Activities

* Subpart (B)—Allows Heartland, without preapproval from the DOJ, to employ or acquire an unlimited number of physicians who are not currently located in Buchanan County, so long as less than 20% of the physician's income was derived from patients living in Buchanan County;

* Subpart (C)—Puts no limit on the number of new doctors that Heartland can bring into Buchanan County to work for Heartland (as employees or through acquiring their practice), so long as Heartland incurs substantial costs in recruiting the doctors, or gives them substantial financial support or income guarantees. Even though the acquisitions require prior notice to the DOJ, approval is given if the financial criteria are met.

* Subpart (D)—Allows Heartland, with prior DOJ, approval, to acquire the practice or employ any physician who finds he or she cannot practice in Buchanan County *unless* hired by Heartland. This provision underscores the real effect of Heartland's monopoly power, i.e. if independent physicians cannot compete successfully with doctors owned by Heartland, they have to join Heartland to survive.

* The practical effect of the foregoing provisions is that Heartland's physician base will continue to grow and monopolize the market for GAPC physicians in Northwest Missouri and Northeast Kansas, leaving sole practitioners with little choice but to join Heartland or move their practices elsewhere.

B. Part X–XI: Compliance Program/Certifications

* Requires only self-reporting of Heartland's proposed acquisitions or other actions covered by the Final Judgment and an annual certification by the defendants that the Final Judgment terms are being adhered to.

* Although the DOJ is to be given ''access'' to defendant's records and personnel and the right to obtain written reports from any defendants, there is no *requirement* that written reports be made to the DOJ by any of the defendants, and no requirement that the DOJ *will* conduct annual, or better yet, semi-annual inspection of books and records and interview of personnel.

* Without an affirmative requirement of regular, periodic written reports or DOJ inspections to determine compliance, it will be virtually impossible to determine whether violations of the Final Judgment have occurred.

* The proposed Final Judgment should give the Court broader powers to monitor and enforce the final judgment. For comparison, see Judge Oliver's opinion in *United States* v. *Associated Milk Producers, Inc.,* 394 F.Supp. 29, 46 (W.D. Mo. 1975), entering a Supplemental Order establishing the manner in which alleged violations of a final judgment entered upon a proposed consent decree should be brought before the Court for appropriate judicial enforcement proceedings.

The Coalition welcomes the opportunity to engage in meaningful discussions with the Department of Justice to clarify and supplement the foregoing arguments and to assist in any manner possible to assure that the Final Judgment in this case is truly in the public's interest.

The Coalition looks forward to a response from the Department of Justice to this Comment.

Very truly yours,

Glenn E. Davis, Esq.

Thomas M. Bradshaw, Esq.

Dianne M. Hansen, Esq.

DMH/kag

cc: Coalition for Quality Healthcare
The Hon. Howard F. Sachs, Sr. District Judge
Clerk of the District Court, Western District of Missouri
Bennett C. Rushkoff, Esq., Assistant Attorney General for the State of Missouri

Ozarks Medical Center

1100 Kentucky Avenue, P.O. Box 1100, West Plains, Missouri 65775, (417) 256–9111, FAX (417) 257–6770

November 17, 1995.

Gail Kursh,

Chief, Professions & Intellectual Property Section, Health Care Task Force, Department of Justice, Antitrust Division, 699 E Street, N.W., Room 9300, Washington, DC 20530

Re: United States v. Health Choice of Northwest Missouri, Inc., et al., Case No. 95–6171–CV–SJ–6, U.S. District Court for the Western District of Missouri

Dear Ms. Kursh: I am writing *in support* of the proposed final judgement for the above mentioned case, specifically related to the discharge process and referrals to hospital-based HHA, DME and hospital affiliates.

As a hospital vice president, I repeatedly see the discharged process interrupted and made complex by demands that every ambulatory care provider within an hour's drive to our hospital be given access to and, in some cases a guaranteed referral to, patients being sent home for recuperation. OMC demands that discharge workers recite a carefully crafted script that does not mention our many years of quality service and coordination with inpatient services just so that external firms will not claim that we are hoarding referrals to ourselves.

I am especially in opposition to the guidelines suggested by the Coalition for Quality Healthcare. These guidelines, as I understand them, would further drive a wedge between hospital inpatient and outpatient businesses. They would also require hospitals to use a rotational system for referrals among all area providers. This is, in effect, stating that just by starting a new business someone is automatically guaranteed a proportional share of business, irrespective of quality, service or their commitment to the community. The guidelines would also require hospitals to permit freestanding providers a large degree of visitation access to inpatients on hospital property. This would be especially onerous to patients and families during times of illness and crisis. External sales personnel could not be kept from repeated unwanted intrusions into the patient's care setting.

I urge the Department of Justice to stand behind it's initial HHA/DME guidelines. This would permit better coordination of patient care without fostering undue intrusion into the care environment.

Yours truly,

Jeffrey B. Johnston,

Vice President for Operations.

Idaho Home Health, Inc.

800 Yellowstone Ave., Pocatello, ID 83201, (208) 232–1122, (800) 491–2224, fax (208) 232–7941

November 16, 1995.

Gail Kursh,

Department of Justice, Antitrust Division, 600 E St. N.W. Room 9300, Washington, D.C. 20530

Re: Home Health Referral Protocol

Dear Ms. Kursh: We understand the Department of Justice will receive input regarding the recommendations for home health referrals proposed in the *United States v. Health Choice of Northwest Missouri* case. Enclosed are several instances of hospital channeling we uncovered in Idaho. If the DOJ

intends the recommendations only apply for Antitrust issues this distinction should be clearly and expressly stated so entities will not apply it to non anti trust matters. If that is the intent, however, we suggest the recommendations be broadened to include 42 USC 1395a issues. Hospital patient channeling and violation of patient choice are the top issues facing proprietary agencies today.

For your information, in Idaho during 1993 if proprietary home health agencies rather than hospital based agencies had provided the Medicare home health visits the Medicare program would have saved millions of dollars. It goes without saying historically Hospital based home health visits are significantly more expensive than proprietary agencies. If the Government was really serious about saving Medicare money it would discontinue facilitating a situation that lends itself to inefficient use of taxpayer dollars. You must be aware the primary motivation behind hospitals entering the home health market is to ''cost shift'' hospital overhead to the home health agency to increase the visit cost up to Medicare program limits. By doing this hospitals can ''cost shift'' millions of hospital dollars into the home health agency thereby improving the bottom line of the hospital.

We suggest a protocol of first asking the patient if they have a preference of home health agencies. If the answer is affirmative then refer the patient to that agency. If the answer is negative the patient is then provided a list of agencies and the patient is advised to call each agency and inquire regarding charges and quality of service. Since none of the other agencies can solicit the patient while in the hospital it is unfair to allow the patient to be solicited by the hospital discharge planner on behalf of the hospital agency. Alternatively, allow the other agencies access to the patient at the time of discharge to also recommend their services similar to what the DOJ is allowing the hospital employees to do. To allow the hospital discharge planner, who is not an employee of the hospital agency, to say the hospital's agency provides quality care and it cannot comment on the quality of care at other agencies is the same as channeling the patient. To assume otherwise reflects a lack of understanding of the market place.

Medicare law prohibits rebates or kickbacks for patient referrals. If the hospital is cost shifting part of its administrative overhead to the home health agency and the discharge planners salary is part of that overhead allocation then the DOJ is condoning violation of Medicare law. The DOJ recommendation also fails to indicate what sanction will take place if the recommendations are violated.

This issue is most difficult and complex and affects thousands of home health agencies. It may also cost our Government billions of unnecessary taxpayer dollars. Please consider the above.

Sincerely,

William F. Bacon,

Vice President & General Counsel.

Health Data Services, Incorporated

November 22, 1995.

Gail Kursh,

Chief, Professions & Intellectual Property Section/Health Care Task Force, Department of Justice, Antitrust Division, 600 E Street, NW., Room 9300, Washington, DC 20530

Re: U.S. vs. Health Choice of Northwest Missouri, Inc. et al., Case Number 95–6171–CV–SJ–6, U.S. District Court, Western District of Missouri

Dear Ms. Kursh: Our business is in Home Health Care; Infusion, Durable Medical Equipment and Home Health. The referrals come from sources within the hospital walls. As we continue to see more hospitals get involved in the Home Health side of the business, outside the confinement of the hospital, our referrals continue to dry up. The staff is instructed to provide minimal amount of information about alternative sources, furthermore, many of the physicians are pressured ever so slightly to use the Hospital Services. The patient's benefits are not looked after, only the financial concerns of the hospital. As we continue to see the dramatic changes in the hospital, they will attack the most vulnerable, the independent providers of Home Health Services, gobble them up and provide less choices for the patients. If our justice system continues to allow the monopolizing of services by the hospitals, the smaller communities will end up with the hospital as the only choice.

Sincerely,

Glen H. Beussink,

Executive Director of HDS.

Gentle Homecare, Inc.

505 Laurel Avenue, Suite 203, Highland Park, IL 60035, Tel: 708/432–9100 or 312/764–5920, Fax: 708/432–9221.

November 22, 1995.

Gail Kursh,

Chief, Professions & Intellectual Property Section/Health Care Task Force, Dept. of Justice, Antitrust Division, 600 E Street, NW., Room 9300, Washington DC 20530

Re: U.S. v. Health Choice of Northwest Missouri, Inc., et al., Case No. 95–6171–CV–SJ–6, In the U.S. District Court for the Western District of Missouri

Dear Ms. Kursh: We vehemently oppose the referral policy currently blessed by the Dept. of Justice in an agreed-upon proposed settlement between the Dept. of Justice and Heartland Health System Inc., St. Joseph, MO.

If this court decision becomes final, it will effectively create regional monopolies. Free-standing home health agencies will be put out of business, because you have now cut us off from out patients, and given us no means to compete.

Please reconsider—there have to be stronger limitations on the hospital's ability to refer its patients to its own hospital-based components.

We would appreciate a reply.

Very truly yours,

Susan Siegal,

Administrator.

Home Health Insights, Inc.

111 East Florence Blvd., Suite 1–B, Casa Grande, Arizona 85222–4047, (602) 421–2239, FAX (602) 421–2503

November 23, 1995.

Gail Kursh,

Chief, Professions & Intellectual Property Section/Health Care Task Force, Department of Justice, Antitrust Division, 600 E Street., N.W., Room 9300, Washington, DC 20530

Dear Ms Kursh: I am writing to join my voice with the Coalition for Quality Healthcare in recommending their modifications to your proposed settlement with Heartland Health System of St. Joseph, MO (Case #95–6171–CV–SJ–6). Our community hospital, which does not operate its own home health agency, currently uses a rotation system for spreading referrals among the area HHAs.

Sincerely,

Ross Feezer,

Adminstrator.

Gail Kursh,

Chief, Professions and Intellectual Property Section, Health Care Task Force, Dept. of Justice, Antitrust Division, 600 E. St., N.W., Room 9300, Washington, D.C. 20530

To Whom It May Concern: This is in response to the Dept. of Justice proposed judgement for *United States v. Health Choice of Antitrust Missouri, Inc.* Case #95–6171–CV–SJ–6.

As a health care provider (RN) and consumer, it appalls me to know that hospitals may not be required to inform patients about alternatives in the health care market. Because a hospital informs a client of any available home health agencies does not mean the hospital endorses such agencies. Healthy competition is good for the consumer and serves as a check and balance system. Hospital based agencies would usually monopolize the market if this referral policy is permitted and quality care will be compromised.

Also, economically, competition allows the consumer to get the most service for their money. Please do not permit this to change.

Sincerely,

Julie L. Miller,

RD 2 Box 58, Friendens, PA 15541.

November 15, 1995.

Gail Kursh,

Chief, Professionals and Intellectual Property, Health Care Task Force, Department of Justice, Anti-Trust Division, 600 E Street, NW., Ste 9300, Washington, DC 20530

Dear Mrs. Kursh: In response to the article ''Courts Use Antitrust Law to Thwart Efforts to Limit Spread of Managed Care'', in the *Employee Benefit Plan Review,* I must agree with the actions of the court to limit the actions of the managed care organization

''Health Choice''. The primary concern that I found when reading this article is the fact that St. Joseph Hospital is a for-profit hospital. All activities which this hospital indulges itself are done to increase the financial status of the hospital, thus causing extensive investigation to occur with every public action in which it participates. I feel that had this been a non-profit hospital no complaint would have been filed due to the fact the company is operating to provide a better care service for the community. It is possible that Health Choice is operating to provide a service to assist in the health care of the community but due to the fact that they are for-profit diminishes this idea, primarily because all surplus revenue will not only be used for the hospital's needs but it will be distributed among the staff of the hospital. So who is really benefiting from this conglomerate.

In a second observation, the restrictions set upon Health Choice do not punish or fine the institution for its practices, it just prohibits any future activity. In light of these penalties Health Choice still retains 85% of the physicians working or residing in the area, this is still a monopoly because the remaining 15% will not be able to adequately compete in the quantity of service which they provide. I believe more drastic measures should be taken or else the Health Choice Network will eventually gain 100% of the market, due to the fact that the remaining 15% join the organization or relocate their practice.

I look forward to hearing your response to these observations and thank you for the opportunity to voice my opinion.

Sincerely,

David L. Hutchinson,

Public Administration Student, Michigan State University.

VNA HealthCare Services

1789 South Braddock Avenue, P.O. Box 82550, Pittsburgh, PA 15218, 412/256–6910, fax 412/256–6920

November 24, 1995.

Ms. Gail Kursh,

Chief, Profession & Intellectual Property Section/Health Care Task Force, Antitrust Division, U.S. Department of Justice, 600 E. Street, N.W., Room 9300, Washington, D.C. 20530

Re: *United States v. Heartland Health Systems Inc., Civil Action No. 95–6171–CV–SJ–6*

Dear Ms. Kursh: This comment is submitted to urge the Justice Department either to modify or, alternatively, to delete entirely the ''Referral Policy'' regarding the provision of ancillary services that is attached to the Final Consent Judgment against Heartland Health System, Inc. For reasons explained below, that ''Referral Policy'' would put the Justice Department's official approval on a policy that is seriously deficient from both a practical and a legal standpoint.

I am the Executive Director of VNA HealthCare Services, which has been serving the residents of Allegheny County, Pennsylvania since 1919—more than 75 years. We have enjoyed an outstanding record of high quality services to the community and, as a non-profit organization, provide services to many individuals without resources. Independent home health agencies, such as VNA HealthCare Services, are dependent in substantial part on patient referrals from hospitals and the physicians on their medical staffs. Our experience in the Pittsburgh area is similar to that across the country, in that approximately 76% of our patients come to us directly from hospitals. Reasonable access to those patients, who include persons with private and governmental insurance, is essential to our survival.

Recent changes in reimbursement methodologies have given hospitals an incentive to''steer'' patients to hospital-affiliated home health care or other ancillary services. Steering of that sort typically involves: (1) Denying representives of competing home health agencies access to hospital premises and patients, even patients who were under the care of the competing home health agency prior to their hospital admissions; (2) refusal to provide patients with brochures or other information regarding competing home health agencies; (3) subtle and not-so-subtle pressure on patients to select the hospital-affiliated agency; and (4) pressure on hospital staff physicians to make referrals to the hospital-affiliated home care provider.

It is no exaggeration to say that the spread of these practices has reached epidemic proportions.

The Heartland referral policy does nothing to address the access and informational concerns that arise in a market in which consumers (the patients) are typically uninformed about their options. Contrary to the stated goal of the Competitive Impact Statement, the referral policy does not prevent a dominant hospital such as Heartland from foreclosing competition and abusing its control over inpatient hospital services to further its position in the provision of ancillary services, such as home health care. Under the Heartland policy, the hospital's ''referring person'' need not even identify competing agencies of which it is aware unless a patient specifically asks twice about alternatives to the hospital's ancillary service. This is clearly not in keeping with federal regulations requiring the hospital to conduct a discharge planning process devoted to patient concerns and long-term best outcomes. Without sufficient patient input in the decision-making process, an inequitable and manipulative atmosphere will result, given that many patients are already frail, confused or distracted from their normal decisionmaking capabilities at time of discharge.

Furthermore, in the proposed policy the hospital referring person is actually encouraged to make what may well be a false statement regarding lack of knowledge about the alternative providers. A discharge planning department's reason for being is to know what the community resources are and to facilitate making them available. For the Heartland patient population, however, at no time is the hospital obligated to provide brochures or other printed information about alternatives to the hospital's affiliate. The referring person may, however, extol the virtues of Heartland's ''excellent, fully accredited,'' ancillary service and provide a Heartland brochure.

If the Justice Department is concerned about stopping the erosion of competition in home health care and other ancillary services, we respectfully submit that it should seek substantial modifications in the Heartland Referral Policy. The modification suggested below would help to restore competition from smaller, independent providers, but these are certainly not the only approaches.

First, Heartland should be obligated to provide patients with information about all accredited home health care agencies in its service area. Such a requirement could be modeled after that which the Commonwealth of Pennsylvania imposed earlier this year, as a condition of its approval of a merger between two hospitals in Harrisburg, Pennsylvania. (A copy of that negotiated settlement provision which has not yet been entered by the court, and the Pennsylvania Attorney General's press release announcing the settlement, are attached to this comment.) Paragraph 19 of that settlement would require the hospitals' discharge planners to provide each patient requiring home health care services or home infusion services with a list of all accredited agencies, and a ''patient choice form,'' which is attached to the settlement agreement as Exhibit 2. That Documentation of Choice form affirmatively states that, ''Basic information on each agency will be provided to assist you in your decision.'' It adds that ''any agency which you desire will be contacted on your behalf,'' and emphasizes that a selection of any agency other than the hospitals' affiliate ''will in no way affect your care at [the hospital] or prevent you from receiving future care at [the hospital].''

Second, the hospital's referring person should be prohibited from espousing the benefits of the hospital's affiliate unless competing agencies are given an equal opportunity to participate in a legally appropriate manner in the discharge planning process, and equal access to the patient or the patient's family.

Third, the hospital should be required to allow at least one home health coordinator from a competitor other than the hospital affiliate, to be available on site.

Fourth, the hospital's referring person should be required, before asking if the patient has a preference, to state affirmatively that alternatives to the hospital's affiliate are available, that the patient will be given a list of these alternatives (by name, address and phone number) and that the referring person will assist the patient in contacting them if the patient so desires.

Fifth, if the patient and the patient's family have no preference, and no desire for written information, then the patient's physician should make the choice of a home care provider.

Sixth, Heartland should be prohibited from directly or indirectly putting pressure on the doctors on its medical staff to refer patients to the hospital's affiliated services.

My suggestions are intended to guide dominant hospitals in complying with the

very general mandates of the Medicare ''freedom of choice'' provision and the Sherman Act. The former statute provides simply that ''(a)ny individual entitled to insurance benefits under this title may obtain health services from any institution, agency, or person qualified to participate under this title if such institution, agency or person undertakes to provide him such services.'' 42 U.S.C. § 1395a. Unfortunately, courts have held that foreclosed providers have no private right of action for violation of this section. Therefore, absent more forceful action by the Government's law enforcement agencies, the patient's right to choose his provider of home care or other ancillary services will remain a largely illusory one.

As you are undoubtedly aware, a plethora of antitrust cases have recognized the Sherman Act issues that should, but evidently do not, constrain the actions of vertically integrated hospitals. These include the *Key Enterprises* v. *Venice Hospital* case in Florida, and the *M&M Medical Supplies* case in Virginia. Since resort to antitrust litigation remains a prohibitively expensive proposition for most home care and ancillary service providers, this threat has not deterred hospitals from engaging in exclusionary conduct.

Although the Heartland consent decree, will, of course, not have any formal precendential value, health care providers have become accustomed to careful scrutiny of consent decrees, business review letters, and informal advisory opinions for signs regarding the direction of antitrust policy. I respectfully submit that the proposed Heartland Referral Policy sends the wrong signal—a signal that hospital discharge planners and social workers must merely go through the motions of advising their patients about alternatives to the hospital's affiliated services. A much more aggressive policy is required to comply with the hospital's existing obligations to provide its patients with freedom of choice. Nothing less will overcome the access and informational gaps that permit hospitals to exploit patients at a time when they are particularly vulnerable to steering tactics.

If I can provide any further information regarding the problems that our home health agency and other VNAs have encountered in our efforts to compete with hospital-owned and hospital-based home health agencies, please do not hesitate to contact me.

Thank you in advance for your consideration of this comment.

Respectfully submitted,

Andrew R. Peacock

ARP:eu

In the United States District Court for the Middle District of Pennsylvania

Commonwealth of Pennsylvania, Plaintiff, v. Capital Health System Services and Polyclinic Health System, Defendants. Civil Action No. .

Final Judgment

Whereas the Commonwealth of Pennsylvania (''Commonwealth'') filed a Complaint in this matter on _____, as a direct purchaser of inpatient acute-care hospital services in Cumberland, Dauphin, and Perry Counties and as *parens patriae* to protect its general economy, pursuant to section 7 of the Clayton Act, 15 U.S.C. § 18;

Whereas Capital Health System Services (''CHS'') and Polyclinic Health System (''PHS'') agreed on September 28, 1994, to merge these two independent health-care entities (hereinafter referred to as ''New Co'') into an integrated community health-care delivery system for central Pennsylvania;

Whereas New Co is expected to generate a net cost savings of at least $70 million over the first five-year period following implementation and annual savings thereafter of about $21 million, to improve quality of health care for central Pennsylvania residents, and to increase access to health care services for central Pennsylvania residents, including the indigent and the otherwise underserved;

Whereas the Office of Attorney General of the Commonwealth (''Attorney General'') is responsible for enforcement of the federal antitrust laws and is authorized to bring suit on behalf of the Commonwealth as a direct purchaser of inpatient acute-care hospital services and as *parens patriae* to protect its general economy;

Whereas CHS and PHS have cooperated fully with the Attorney General's investigation of the proposed consolidation;

Whereas the Attorney General has concluded its investigation of the proposed consolidation of the two health-care systems and believes that, without this Final Judgment, it may raise anticompetitive concerns under the federal antitrust laws;

Whereas CHS and PHS desire to assure the Attorney General and the community that they intend to operate New Co in accordance with their mission and continue their commitment of providing quality, affordable health care to the community;

Whereas CHS and PHS, desiring to resolve the Attorney General's concerns without trail or adjudication of any issue of fact or law, have consented to entry of this Final Judgment; and

Whereas this Final Judgment is not an admission of liability by CHS, PHS, or New Co as to any issue of fact or law and may not be offered or received into evidence in any action as an admission of liability; it is hereby ORDERED:

I. Jurisdiction

1. This Court has jurisdiction over the subject matter of this action and each of the parties consenting to this Final Judgment. The Complaint states a claim upon which relief may be granted.

II. Definitions

As used in this Final Judgment:

2. ''Capital Health System Services'' (''CHS'') means the nonprofit tax-exempt corporation organized under the laws of the Commonwealth of Pennsylvania that is the corporate parent of Harrisburg Hospital (''HH''), a nonprofit tax-exempt hospital located at 111 South Front Street, Harrisburg, Pennsylvania, and Seidle Memorial Hospital (''SMH''), a nonprofit tax-exempt hospital located at 120 South Filbert Street, Mechanicsburg, Pennsylvania.

3. ''Polyclinic Health System'' (''PHS'') means the nonprofit tax-exempt corporation organized under the laws of the Commonwealth of Pennsylvania that is the corporate parent of the Polyclinic Medical Center (''PMC''), a nonprofit tax-exempt hospital located at 2601 North Third Street, Harrisburg, Pennsylvania.

4. ''New Co'' means the nonprofit corporation that CHS and PHS will create pursuant to their September 28, 1994, agreement to merge.

5. ''Member Hospital'' means HH, PMC or SMH.

6. ''Managed-Care Plan'' means a health maintenance organization, preferred provider organization, or other health-service purchasing program which uses financial or other incentives to prevent unnecessary services and includes some form of utilization review.

7. ''Health Plans'' means all types of organized health-service purchasing programs, including but not limited to managed-care plans, offered by third-party payors, health-care providers or any other person.

8. ''Health-Care Provider'' means physicians, hospitals, laboratories and physician networks.

9. ''Acquire'' means to purchase the whole or the majority of the assets, stock, equity, capital or other interest of a corporation or other business entity, or to receive the right or ability to designate the majority of directors or trustees or otherwise control the management of a corporation or other business entity.

10. ''Net Cost Savings'' means the difference between the total expenditures that CHS and PHS would have incurred absent the consolidation of the two health systems and their total expenditures actually made, minus the total expenditures incurred to implement the consolidation into New Co. As a guide to help calculate net cost savings, the parties will use the

Efficiency Study for the Consolidation of CHS and PHS, dated November 1994, as amended.

11. ''Hospital'' means a health care facility, licensed as a hospital, having a duly organized governing body with overall administrative and professional responsibility, and an organized professional staff that provides 24-hour inpatient care, that may also provide outpatient services, and having as a primary function the provision of inpatient services for medical diagnosis, treatment, and care of physically injured or sick persons with short term or episodic health problems or infirmities.

III. Terms

12. *Anticipated Savings and Price Reductions.* CSH and PHS intend to merge and consolidate services into New Co, increase efficiency, and reduce the cost of delivering health-care services so that the cost to the community of those services will be lower than they would have been absent the merger.

12.1 New Co shall achieve in 199__ constant dollars at least $70 million in net cost savings by [five years after closing]. At least 80% of the net cost savings New Co achieves in each of the first five years shall be passed on to consumers or other purchasers of health-care services in the form of low-cost or no-cost health-care programs for the community or by reducing prices or limiting actual price increases for existing services. Prior to passing on any such cost savings to consumers or other purchasers of health-care services in the form of low-cost or no-cost health-care programs, New Co shall submit in writing to the Office of Attorney General their proposal(s) for passing on such cost savings, which will be automatically approved unless the Office of Attorney General objects to any specific proposal within ten (10) business days following receipt of such proposal. At a minimum, the following cumulative net cost savings shall be passed on; $0 by [one year after closing]; $5.6 million by [two years after closing]; $24 million by [three years after closing]; $40 million by [four years after closing]; and $56 million by [five years after closing]. These savings shall be documented in the annual report described in Paragraph 23. The parties will develop a mutually-agreed upon model to measure the net cost savings on a case mix, inflation index adjusted net cost per admission basis in comparison to pre-merger costs, and the cumulative net cost savings passed on to consumers on a case mix, inflation index adjusted net revenue per admission basis. If New Co fails to meet the targeted net cost savings in any given fiscal year, the shortfall amount shall be carried forward into subsequent fiscal year until the full net cost savings amount has been realized by New Co, including the portion to be passed on as described above. If New Co exceeds the targeted net cost savings in any given year, the excess amount shall be credited towards New Co's target for the next fiscal year.

12.2 If by [five years after closing], New Co has not achieved $70 million in net cost savings, New Co shall pay in cash an amount equal to $70 million less the amount of savings actually achieved into a fund established by the Attorney General. The Attorney General shall use this money to fund low-cost or no-cost health-care services to Cumberland, Dauphin and Perry County residents, such as child immunizations, mammograms, drug and alcohol abuse treatment programs, or other health-care services needed by the community for which adequate resources are not available. The Attorney General shall select, after receiving any input from New Co, a charitable organization to administer these funds. If New Co has not achieved $70 million in net cost savings, New Co shall have an opportunity to demonstrate, to the satisfaction of the Attorney General, that circumstances beyond its control have prevented achievement of the savings.

12.3 If by [five years after closing], New Co has not achieved at least $66.5 million of the anticipated net cost savings, the restrictions on changes in the case-mix adjusted net inpatient revenue per admission contained in Subparagraph 12.4 shall continue until [ten years after closing], regardless of whether the Final Judgment is terminated any time earlier pursuant to Paragraph 33.

12.4 New Co's case-mix adjusted net inpatient revenue per admission for all inpatients treated during the fiscal year under consideration at member hospitals (hereinafter ''Revenue''), in fiscal years subsequent to 1994–95, shall not exceed the combined Revenue of the member hospitals for 1994–95, as adjusted pursuant to Subparagraph 12.5, and excluding the effects of New Services, as defined in Subparagraph 12.6, outliner cases, and externally imposed requirements, including but not limited to changes in payment methods or reimbursement methods imposed or implemented by state or federal regulations.

12.5 In determining compliance with Subparagraph 12.4, Revenue shall be adjusted (up or down) for changes in the Consumer Price Index-Urban, plus two percent.

12.6 ''New Services'' means either (a) services not listed on Exhibits 1–A, 1–B or 1–C (copies of which are appended hereto), which list services provided at each of the member hospitals as of entry of this Final Judgment; or (b) material changes in community need, technology, or sophistication of treatment which either (i) require a certificate of need or (ii) require a combination of new capital, personnel and supply expenditures in excess of $100,000 in any fiscal year. Upon request by the Attorney General, New Co shall provide all information and documentation reasonably necessary to support the application of this subparagraph. If New Services are provided, they shall be described in the annual report to the Attorney General, required by Paragraph 23.

12.7 If New Co fails to comply with Subparagraph 12.4, it shall reimburse the excess by lowering its rates in the next fiscal year in an amount equal to the excess. If New Co exceeds the targeted Revenue savings in any given year, the savings amount shall be credited towards New Co's target for the next fiscal year. In the annual report described in Paragraph 23, New Co shall describe its compliance with this subparagraph.

12.8 Subparagraphs 12.3, 12.4, 12.5, 12.6, and 12.7 shall apply only during those fiscal years when the Commonwealth of Pennsylvania or the federal government does not substantially regulate hospital rates.

13. *Nonexclusivity.*

13.1 New Co shall not enter into any provider contract with any health plan on terms that prohibit New Co from entering into a provider contract for any services New Co offers with any other health plan.

13.2 New Co shall not require managed-care plans to contract with its employed doctors as a precondition to contracting with its member hospitals.

13.3 New Co shall not restrict an independent physician's ability to provide services or procedures outside the member hospitals, unless performance of duties outside the member hospitals would impair or interfere with the safe and effective treatment of a patient.

13.4 New Co shall not prohibit independent physicians who are members in any New Co physician-hospital network from participating in any other physician-hospital networks, health plans, or integrated delivery systems.

14. *Nondiscrimination.*

14.1 New Co shall not enter into any exclusive contracts with any health-care provider by which it requires that

provider to render services only at a member hospital or by which it requires only one physician or group of physicians to provide particular services at a member hospital. New Co may enter into exclusive contracts with anesthesiologists; radiologists; nuclear medicine physicians; pathologists; physiatrists; emergency-room physicians; neonatologists; perinatologists; cardiologists, cardiovascular surgeons, and neurologists for interpretive services only; radiation oncologists; and physicians providing services in New Co's low-income clinics, so long as these contracts are competitively bid at least once every three years and the bidding specifications affirmatively require the winning physician(s) not to refuse unreasonably to participate in any health plans that have provider contracts with the member hospitals. This provision, however, shall not require New Co to terminate any existing contracts, and New Co may require its employed physicians to render services only at member hospitals. New Co may also petition the Attorney General for approval to enter into exclusive contracts with physicians in specialties other than those listed above. The Attorney General shall provide New Co with a response to the petition within ninety (90) days.

14.2 Other than as provided in Paragraph 14.1, New Co shall provide an open staff, ensuring equal access to all qualified physicians in Cumberland, Dauphin, and Perry Counties according to the criteria of the Joint Commission on Accreditation of Health Care Organizations and the medical staff by-laws.

14.3 New Co shall negotiate in good faith with all health plans with a licensed service area within Cumberland, Dauphin, or Perry Counties which approach it seeking a provider contract. This provision, however, shall not be construed to require a New Co to enter into a provider contract with any particular health plan.

14.4 New Co shall not enter into provider contracts with any licensed health plan operated by New Co itself, in existence now or which may be created, on terms available to that plan solely because it is sponsored by New Co, where doing so would place other comparable licensed health plans at a competitive disadvantage, because of any market power New Co may have rather than from efficiencies resulting from its integration with its health plan.

14.5 With respect to Health Central, Inc., the new managed-care plan proposed by six south central Pennsylvania hospitals, including CHS, New Co will participate in this plan only on nonexclusive terms. Further, New Co will not engage in any ''most-favored-nation'' pricing with respect to this plan vis-a-vis other competing managed-care plans in its market, and will not cross-subsidize Health Central, Inc. through the operating revenues of New Co in a manner that would facilitate predatory pricing or other anticompetitive conduct. New Co shall disclose, as part of its annual report pursuant to Paragraph 23, all funds that were provided by New Co to Health Central, Inc. during the preceding fiscal year.

14.6 New Co will not use employment, the location of a physician or group practice, or the location where patients will receive any necessary follow-up care to determine referrals from the emergency room. New Co may consider quality of care and reasonable proximity for patient convenience in determining referrals. The referral policy used to inform unassigned patients of the availability of follow-up care shall be provided to the Attorney General within thirty (30) days from entry of this Final Judgment. Should the Attorney General object to this policy, the parties shall attempt to reach a mutually satisfactory resolution. This subparagraph shall not preclude any managed-care plan operated by New Co from limiting referrals to providers with provider contracts with that plan.

14.7 Except as provided in Paragraph 14.1, if New Co establishes or sponsors its own health plan, it shall not base credentialing decisions or other decisions affecting a physician's access to, or working conditions at, a member hospital on whether that physician enters into a provider contract with either New Co's plan or with a competing plan.

15. *Health Plans.*

15.1 New Co will not unreasonably terminate any provider contracts to which its member hospitals are parties as of the date of entry of this Final Judgment.

15.2 New Co shall attempt, in good faith, to contract with all health plans operating in its service area which offer commercially-reasonable terms on a fully-capitated basis, a percentage of premium revenue basis, or on other terms that require New Co to assume risk. New Co shall not refuse to contract with a health plan solely because such plan proposes a capitated contractual reimbursement methodology. This provision, however, does not require New Co to enter into a provider contract with any particular health plan or with all health plans.

16. *Employment of Physicians.*

16.1 New Co shall be prohibited from employing more than 20% of the physicians in Cumberland, Dauphin and Perry Counties practicing in any of the following areas: family practice/internal medicine, pediatrics, or obstetrics/gynecology, except as provided in Subparagraph 16.2. In calculating this percentage, full-time residency faculty members employed by New Co shall be counted as one half each and physicians employed at the HH or PMC low-income clinics shall be excluded.

16.2 New Co may recruit and employ physicians from outside Cumberland, Dauphin, and Perry Counties into those counties, in any of the enumerated areas listed in Subparagraph 16.1 without regard to or in violation of the 20% limitation in that subparagraph.

16.3 In determining New Co's compliance with Subparagraph 16.1, up to 79 residents employed by New Co shall be excluded. Additional residents beyond 79 shall be counted at one half each.

16.4 New Co shall not solicit the employment of any physician or group practice within Cumberland, Dauphin, and Perry Counties if such employment would cause New Co to exceed the limitations imposed by Subparagraph 16.1.

16.5 New Co may petition the Attorney General in writing for an exception to Subparagraph 16.1 when market conditions exist for employing physicians in any of the enumerated categories above the 20% limitation level. The Attorney General will respond to the petition within thirty (30) days from the receipt of all information reasonably necessary from New Co to analyze the petition.

17. *Operating Room Scheduling.* Operating room scheduling shall be determined by an Operating Room Committee that includes physicians, operating room nurses, and representatives of hospital administration, according to the following criteria:

17.1 Operating room time will be assigned in blocks based on physicians' demonstrated need for access to operating rooms.

17.2 These assignments will be updated quarterly, based on actual usage of block time. If a particular slot is not reserved by the physician to which it is allocated prior to 24 hours before the time of that slot, the time will be released and will be assigned to other physicians on a first-come first-served basis. If a physician is not utilizing a sufficient amount of reserved time, that physician's block time will be

reassigned at the time of the quarterly update.

18. *''Most-Favored-Nation'' Provisions in Contracts With Health Plans.* New Co shall not enter into any provider contract with any health plan on terms which include a most-favored-nation clause to the benefit of New Co or any health-care plan. A most-favored-nation clause is any term in a provider contract that allows the buyer to receive the benefit of any better payment rate, term or condition that the seller gives another provider for the same service. In the case of any existing most-favored-nation clause to the benefit of New Co or any health-care plan in current provider contracts, New Co agrees not to renew or extend such contracts without deleting that term. New Co shall inform the Attorney General of the presence of a most-favored-nation clause in any existing provider contracts by providing a list of such contracts to the Attorney General not more than thirty (30) days from entry of this Final Judgment.

19. *Ancillary Services.* CHS shall, as soon as is practicable but in no event later than twelve (12) months of entry of this Final Judgment, divest all of its assets and interests in Capital Health Products, its durable medical equipment company, to a third-party buyer. Further, New Co shall not require any healthcare purchaser or patient to purchase home health services or home infusion therapy services from any entity affiliated with New Co. If companies not affiliated with New Co cannot provide services in a manner that would permit New Co to contain costs in the context of risk-bearing contracts, New Co may require these services to be purchased from a company affiliated with New Co. In all other circumstances, New Co shall affirmatively inform patients and providers needing home health-care services or home infusion therapy services of the availability of such services from companies not related to New Co. In this regard, New Co's discharge planners must provide each patient requiring home health-care services or home infusion therapy services with a patient choice form, which is appended as Exhibit 2, and with a list of all home health-care and home infusion therapy agencies accredited by the Joint Commission on Accreditation of Health Care Organizations serving Cumberland, Dauphin, and Perry Counties. This provider list must be updated at least quarterly if New Co is requested to do so by a qualified agency; and, if a home health-care or home infusion therapy agency that is not affiliated with New Co is selected by the patient, that agency must be given reasonable access to the patient's records and to the member hospital's premises so that it may begin providing needed services to that patient. The provisions of this paragraph will also be applicable to CHS's durable medical equipment company until the sale of that company is completed.

20. *Certificates of Need.* New Co shall not oppose certificates-of-need applications filed by other hospitals or other health-care providers with the Pennsylvania Department of Health unless it notifies the Attorney General in writing, as soon as practicable but at least seven (7) days prior to filing any opposition, and provides a copy of any opposition to the Attorney General when it is filed with the Department.

21. *Future Sales and Acquisitions of Hospital Assets.* New Co shall not, without the prior approval of the Attorney General, acquire any indemnity plan, health maintenance organization, or hospital in Cumberland, Dauphin, or Perry Counties or permit any indemnity plan, health maintenance organization, or hospital in these counties to acquire New Co. New Co may not enter into any joint ventures with any hospital in Cumberland, Dauphin, or Perry Counties; acquire any hospital outside Cumberland, Dauphin, or Perry Counties; or permit any hospital outside Cumberland, Dauphin, or Perry Counties to acquire New Co, without first giving at least 60 days notice to the Attorney General. The preceding sentence, however, shall not apply to joint ventures to provide residency programs or to joint ventures with annual operating costs of below $100,000.

22. *Binding on Successors and Assigns.* The terms of this Final Judgment are binding on New Co and its directors, officers, managers and employees, successors and assigns, including but not limited to any person or entity to whom New Co may be sold, leased or otherwise transferred, during the term of its duration, and all persons who are in active concert or participation with them and who have actual or constructive notice thereof. New Co shall not permit any substantial part of New Co to be acquired by any other person unless that person agrees in writing to be bound by the provisions of this Final Judgment.

23. *Reporting Mechanism.*

23.1 Within 150 days from the close of each fiscal year during which this Final Judgment is in effect, New Co shall submit to the Attorney General an annual report accompanied by an officer's compliance certificate describing its compliance with this Final Judgment. This report shall include a discussion of the steps taken by New Co to comply with the efficiencies and services reconfiguration plans and the estimated savings from these steps. The Attorney General will provide notice to New Co of any concerns raised by the annual compliance report within a reasonable time after its issuance. New Co will meet with the Attorney General to attempt to resolve any concerns that the Attorney General may raise from its review of the report.

23.2 New Co will reimburse the Attorney General for expenses, including the payment of any expert fees, incurred in analyzing and verifying this report, in an amount not to exceed $10,000 per year. Within sixty (60) days from entry of this Final Judgment, New Co will pay the Attorney General $5,000 to establish a mutually-agreed upon model to be used to analyze compliance. This amount shall be deducted from the first year's reimbursement requirement. New Co will cooperate with any expert hired by the Attorney General, including but not limited to providing any additional requested information reasonably necessary to complete the analysis and verification of the compliance report.

24. *Publication of Efficiency Report.* New Co shall prepare, subject to the Attorney General's approval, a condensed version of its efficiency report to be released to the general public within fourteen (14) days from entry of the Final Judgment.

25. *Compliance.* To determine or secure compliance with this Final Judgment, any duly authorized representative of the Attorney General shall be permitted:

25.1 Upon reasonable notice, access during normal business hours to all non-privileged books, ledgers, accounts, correspondence, memoranda, and other records and documents, in the possession or under the control of New Co, relating to any matters contained in this Final Judgment; and

25.2 Upon reasonable notice, access during normal business hours to interview officers, managers or employees regarding any matters contained in this Final Judgment.

26. *Complaint Procedure.* Any person, including health-care providers, health plans, or consumers of medical services, who wishes to report a possible violation of this Final Judgment shall send a written description of the possible violation to the Chief Deputy Attorney General, Antitrust Section, Office of Attorney General, 14th Floor, Strawberry Square, Harrisburg, Pennsylvania 17120 and to New Co's

President, 17 South Market Square, P.O. Box 8700, Harrisburg, Pennsylvania 17105. New Co shall respond in writing to the complainant and to the Attorney General within thirty (30) days from receipt of any complaint. If the complaint is still unresolved, the Attorney General will attempt to negotiate a satisfactory resolution. If New Co believes any complaint to be frivolous, it may so advise the Attorney General, and its obligations under this paragraph will be satisfied unless it is otherwise advised by the Attorney General to respond more fully to the complaint.

27. *Reimbursement of Expenses.* Upon entry of this Final Judgment, CHS and PHS shall jointly pay $50,000 to reimburse the Attorney General's costs incurred to conduct its investigation, which payment shall be used for future Public Protection Division enforcement purposes.

28. *Enforcement.*

28.1 If the Attorney General believes that there has been a violation of this Final Judgment, it shall promptly notify New Co thereof. The Attorney General shall thereafter permit New Co a reasonable opportunity to cure any alleged violation without instituting legal action. If the alleged violation is not substantially cured by New Co within sixty (60) days of notification, the Attorney General may thereafter undertake any remedial action it deems appropriate. This time period shall be extended in circumstances where the sixty (60) day period is not sufficient time to cure the alleged violation.

28.2 In any action or proceeding brought by the Attorney General to enforce this Final Judgment or otherwise arising out of or relating hereto, the Attorney General, if it is the prevailing party, shall recover its costs and expenses, including a reasonable sum for attorneys' fees.

29. *Legal Exposure.* No provision of this Final Judgment shall be interpreted or construed to require New Co to take any action, or to prohibit New Co from taking any action, if that requirement or prohibition would expose New Co to significant risk of liability for any type of negligence (including negligent credentialing or negligence in making referrals) or malpractice.

30. *Notices.* All notices required by this Final Judgment shall be sent by certified or registered mail, return receipt requested, postage prepaid, or by hand delivery, to:

If to the Attorney General:

Chief Deputy Attorney General, Antitrust Section, Office of Attorney General, 14th Floor, Strawberry Square, Harrisburg, PA 17120

If to New Co:

President, New Co, 17 South Market Square, P.O. Box 8700, Harrisburg, PA 17105

31. *Averment of Truth.* New Co avers that the information it has provided to the Attorney General in connection with this Final Judgment, to the best of its knowledge, is true and represents the most recent and comprehensive data available, and that no material information has been withheld.

32. *Termination.* This Final Judgment shall expire on the tenth anniversary of its date of entry if it has not terminated prior to that time as provided in Paragraph 33. Notwithstanding the first sentence of this paragraph, enforcement of Paragraph 16 shall expire on the fifth anniversary of entry of this Final Judgment.

33. *Early Expiration.* After [five years from closing], if New Co has complied with the applicable provisions of this Final Judgment, the Attorney General shall join New Co in an application to this Court for an order terminating, in whole or in part, this Final Judgment. The Attorney General shall not unreasonably refuse to join any such application.

34. *Modification.* If either the Attorney General or New Co should believe that modification of the Final Judgment would be in the public interest because of changed or unforeseen circumstances or for other reasons, that party shall give notice to the other, and the parties shall attempt to agree on a modification. If the parties agree on a modification, they shall jointly petition the Court to modify the Final Judgment. If the parties cannot agree on a modification, the party seeking modification may petition the Court for modification and shall bear the burden of persuasion that the requested modification is in the public interest.

35. *Retention of Jurisdiction.* Unless this Final Judgment is terminated early pursuant to Paragraph 33, jurisdiction is retained by this Court for ten (10) years after entry to enable any party to apply to this Court for such further orders and directions as may be necessary and appropriate for the interpretation, modification and enforcement of this Final Judgment.

Dated this 20th day of July, 1995.

Walter W. Cohen,

Acting Attorney General, Commonwealth of Pennsylvania.

Carl S. Hisiro,

Chief Deputy Attorney General, Antitrust Section.

James A. Donahue, III,

Senior Deputy Attorney General, Antitrust Section, Office of Attorney General, 14th Floor, Strawberry Square, Harrisburg, PA 17120, (717) 787–4530, Attorneys for the Commonwealth of Pennsylvania.

Capital Health System.

John S. Cramer,

President and Chief Executive Officer.

Attest: Cheryl P. Makle

Polyclinic Health, System.

Stephen H. Franklin,

President and Chief Executive Officer.

Attest: M.M. Van Bly

Toby G. Singer, Esquire.

Stephen D. Kiess, Esquire,

Jones, Day, Reavis & Pogue, Metropolitan Square, 1450 G Street, N.W., Washington, DC 20005–2088, (202) 879–3939, Attorneys for Capital Health System and Polyclinic Health System.

So Ordered:

United States District Judge

Exhibit 1–A—Harrisburg Hospital Inpatient Services

General inpatient care for HIV/AIDS
Birthing room/LDRP room
Open-heart Surgery
Cardiac intensive care unit
Angioplasty
Chronic obstructive pulmonary disease service
Hemodialysis
Medical surgical or other intensive care unit
Histopathology laboratory
Neonatal intensive care unit
Obstetrics unit
Pediatric acute inpatient unit
Reproductive health services
Organized social work services
Organ/tissue transplant
Orthopedic surgery
Occupational therapy services
Physical therapy services
Respiratory therapy services
Speech therapy services
Oncology services
CT Scanner
Diagnostic radioisotope facility
Ultrasound
Blood bank
Patient education

Exhibit 1–B—Seidle Memorial Hospital Inpatient Services

Skilled nursing or other long-term care
Organized social work services
Physical therapy services
Recreational therapy services

Speech therapy services

Exhibit 1–C—Polyclinc Medical Center Inpatient Services

General inpatient care for HIV/AIDS
Birthing Room/LDRP room
Cardiac catherization laboratory
Open-Heart Surgery
Cardiac Intensive Care Unit
Angioplasty
Chronic obstructive pulmonary disease service
Emergency Department
Medical surgical or other intensive care units
Neonatal Intensive Care Unit
Obstetrics Unit
Pediatric Acute Inpatient Unit
Psychiatric Inpatient Service
Extracorporeal Shock-Wave Lithotripter
Alzheimer's diagnostic/Assessment Services
Comprehensive Geriatric Assessment
Emergency Response (Geriatric)
Geriatric Clinics
Respite Care
Senior Membership program
Patient Education
Community Health Promotion
Worsite Health Promotion
Hemodialysis
Histopathology Laboratory
Blood Bank
Occupational Health Services
Psychiatric Consultation/Liasion Services
Psychiatric Geriatric Services
Megavoltage Radiation Therapy
Rehabilitation Inpatient Unit
Skilled Nursing or Other Long-Term Care Unit
Orthopedic Surgery
Magnetic Resonance Imaging (MRI)
Therapeutic Radioisotope therapy
CT scanner
Reproductive health services
Single photon emission computerized tomography
Organized social work services
Patient representative services
Occupational therapy services
Physical therapy services
Recreational therapy services
Respiratory therapy services
Speech therapy services
Health sciences library
Cardiac rehabilitation program
Non-invasive cardiac assessment services
Mammography Screening Services
Mammography diagnostic services
Oncology services

Exhibit 2—[New CO] Referrals for Home Health and/or Home Health Equipment—Documentation of Choice

PATIENT: _____
D.O.B. _____

Your physician(s) _____, has recommended that you receive visiting nurse or other home health services after you are discharged from the hospital. A listing of agencies offering visiting nursing and/or home health care services in the region is available for your review. A representative from [New Co] will contact any of these agencies, or any other agency not listed, upon your request. Selection of this agency is your responsibility or that of your family, unless your insurance company, health plan, HMO, or physician (because of special needs) require you to use a particular agency. Basic information on each agency will be provided to assist you in your decision.

Choice of Provider: Include Agency Name, Address and Phone Number

1. Home Health Agency: _____
2. Equipment Provider: _____
3. Other: _____

Reason for Choice: Check all that apply

____Previous Relationship with Home Health Company
____Patient/Family Preference
____Insurance Provider Directive
____Doctor Recommendation/Directive
Explain: _____
____Hospital Recommendation/Directive
Explain: _____
____Other Explain: _____
____Patient/Family No Preference (see below)

In the event that you or your family do not have a preference from the attached list of available agencies, [New Co] can provide this service if you so desire. However, you should be assured that no such referral is required and that any agency which you desire will be contacted on your behalf. Your selection of an agency other than [New Co] will in no way affect your care at [New Co] or prevent you from receiving future care at [New Co].

I have had the opportunity to review information related to home health care services and have had my questions answered to my satisfaction. My selection is as indicated above.

_____
Signature

_____
Date

_____
Relationship (if not patient)

Comments: _____
(If unable to obtain signature)

Person Completing This Form: _____

Commonwealth of Pennsylvania, Office of Attorney General, Harrisburg, PA 17120

For Immediate Release—Thursday, July 20, 1995.

Contact: Jack J. Lewis, Assistant Press Secretary, 717–787–5211 (home: 657–9840).

(Also released via RP Newswire in Central PA.)

HARRISBURG—The Office of Attorney General has approved the Harrisburg Hospital-Polyclinic Medical Center merger ''because we have it guaranteed—in writing—that at least $56 million in savings will be passed on to consumers,'' Acting Attorney General Walter W. Cohen announced today.

Cohen said a proposed settlement negotiated by the Attorney General's office addresses antitrust concerns sparked by the planned merger of Capital Health System (CHS), corporate parent of both Harrisburg Hospital and Seidle Memorial Hospital, with Polyclinic Health System (PHS), corporate parent of Polyclinic Medical Center.

Both Harrisburg Hospital and Polyclinic Medical Center are in Harrisburg; Seidle Memorial Hospital is in Mechanicsburg.

We have negotiated a carefully structured plan that mandates cost savings and—most importantly—guarantees that those savings will be passed on to consumers,'' Cohen said.

''We've also ensured that the new system to be created by this merger will not use its market power to create an unfair advantage over others in the marketplace, health care providers and health plans.

''Without the safeguards included in this agreement, the proposed consolidation of these two health-care systems would have raised significant concerns about the effects on health-care competition in the Capitol area. With these safeguards, we are convinced that this merger will benefit not only the hospitals but also—and this is our bottom line—the people who live in the Harrisburg area.''

Cohen announced the settlement at a news conference also attended by John S. Cramer, CHS president and chief executive officer, and Stephen H. Franklin, PHS president and chief executive officer.

The proposal will be submitted to the Federal Trade Commission for its review, Cohen said. If the FTC agrees to defer jurisdiction to the state, the agreement will be filed in U.S. District Court for the Middle District of Pennsylvania for court approval.

Cohen said the proposed settlement requires the new health-care system to achieve at least $70 million in net cost savings within the first five years after implementation of the merger.

Of that amount, he said, $56 million in savings must be passed on to consumers in the form of free or reduced-cost health-care programs or through adjustments of prices charged for existing services. He noted that cost variables will be monitored by the Attorney General's office.

If the targeted $70 million cost-savings figure is not reached five years after implementation of the merger, the settlement requires the new health system to pay $70 million minus the actual achieved savings to a fund established by the Attorney General's office, Cohen said.

''The fund would be used to supply free or low-cost services such as child immunizations, mammograms, and drug and alcohol abuse treatment programs to residents of Cumberland, Dauphin and Perry counties,'' he said.

Chief Deputy Attorney General Carl S. Hisiro, who heads the Attorney General's

Antitrust Section, said the section interviewed dozens of doctors, health-care insurers, ancillary care providers, personnel from other hospitals, and others in the community during the investigation.

''This agreement responds to many of the anticompetitive concerns raised by those individuals,'' Hisiro said.

The proposed settlement requires the new system to hold overall price increases to changes in the Consumer Price Index-Urban, plus 2 percent, for at least five years. ''This guarantees that there will be no drastic price increases for consumers in the wake of the merger,'' Hisiro said.

The proposal also requires CHS to sell Capital Health Products, its durable medical equipment company, to a third-party buyer within one year.

The new system can't require patients to buy home health-care services from any company affiliated with the new system, and it must provide patients with information about all accredited home health-care agencies in the area, according to the agreement.

Cohen said other provisions included in the settlement which are designed to protect consumers against possible anticompetitive effects of the merger include:

—During its first five years, the new system is prohibited—with certain defined exceptions—from employing more than 20 percent of the physicians in Cumberland, Dauphin and Perry counties practicing in family medicine/internal medicine, pediatrics, and obstetrics/gynecology.

—The new system cannot bar independent physicians who are members of any physician-hospital network established by the new system from participating in other physician-hospital networks or health plans.

—The new system is prohibited from entering into an exclusive contract or providing special benefits to any single health plan. The system must negotiate in good faith with all health plans serving the Capitol area.

—The new system is barred in most cases from entering into exclusive contracts with health-care providers.

Cohen said that if the new system participates in Health Central Inc., a managed-care plan proposed by six south central Pennsylvania hospitals including CHS, the settlement requires that the system participate only on nonexclusive terms.

''The new system is barred from giving this plan any price breaks not offered to other plans, and the system cannot subsidize Health Central through its own revenues in any anticompetitive manner,'' Cohen said.

Under terms of the settlement, the new system cannot—without prior approval of the Attorney General's office—acquire or be acquired by ''any indemnity plan, health maintenance organization, or hospital in Cumberland, Dauphin or Perry counties.''

Cohen said that for five years after the merger takes place, the new system must submit annual reports to the Attorney General's office describing the system's compliance with the eventual final judgment of the court.

Cohen said the term of the settlement is 10 years, although the parties can petition the court to end it after five years if the system has complied with the terms at that time.

In concluding the investigation, Cohen stressed that officials of both CHS and PHS cooperated fully with the investigation. He commended Hisiro and Senior Deputy Attorney General James A. Donahue III for their roles in negotiating the proposed settlement.

Shepard's Crook Nursing Agency, Inc.

P.O. Box 2234, Pampa, Texas 79066, Phone 806/665–0356

November 27, 1995.

Gail Kursh,

Chief, Professions and Intellectual Property Section, Health Care Task Force, Department of Justice, Antitrust Division, 600 E. St., N.W., Room 9300, Washington, D.C. 20530

Regarding: United States v. Healthchoice of Northwest Missouri, Inc.

The main objective in managed health care and the referral system is providing good care for the patient. Variations in agencies are most evident in quality of care and skills of the staff.

Any regulation that restricts patients choices lowers the quality of care the patient receives for the dollar spent.

The Columbia hospital administrator in Pampa, Texas told Shepard's Agency he did not intend to refer to anyone and wanted all the other agencies in town gone. He *wanted* all the business. Many of our patients were forced by the hospital to use the hospital home health while requesting another agency. Many hospitals are now practicing the regulation proposed. The result is evident in patient dissatisfaction and reduced quality of care.

The patient should be treated as a customer of services and not a captive of the discharge planner.

A great majority of patients requiring home health are the elderly. This is a group which has difficulty making demands for a choice. Their rights are usually the ones most abused.

A system which is based on self-referral to the hospital based agency is set up for fraud and abuse. This will result in accelerated utilization, and high cost to Medicare. Hospitals have a great need to shift Medicare money to hospital expenses and increase hospital profit. Due to this practice, free-standing agencies can provide home health cheaper than hospital based agencies.

Hospitals should be required by law to offer patient choices. Agencies should be allowed to visit their patients at the hospital to arrange plans on discharge. If the patient has no preference, referrals should be rotated.

This is a critical time in Health Care. Caution must prevail to lower cost. Giving the hospitals more control over care after leaving the hospital is step in the wrong direction. Protecting patients rights' will help lower medical cost.

The patient should be asked if they have been served by a home health agency. If the patient says at this point yes, they should be asked if they wish to remain. Only if the patient states they do not choose to stay with the same agencies should other agencies be offered. Switching a patient to another agency increases cost in repetitive health care teachings. This should be done only at the *patient's* choice. The patient should have the right to control his own health care. Please find enclosed documented complaints from patients and Shepard's Nursing Home Health on the Columbia Hospital referral system to their home health agency.

Further information is available.

Sincerely,

Suzanne Wilkinson,

Administrator/Owner, Shepard's Crook Nursing Agency, Inc.

Fayette County Health Department

P.O. Box 340, South Fifth and Edwards St., Vandalia, IL 62471, (618) 283–1044

December 1, 1995.

Gail Kursh,

Chief, Professions & Intellectual Property Section/Health Care Task Force, Department of Justice, Antitrust Division, 600 E St. NW., Room 9300, Washington, DC 20530

Re: Proposed final judgment for United States v. Health Choice of Northwest Missouri, Inc., et al., Case No. 95–6171–CV–SJ–6 in the U.S. District Court for the Western District of Missouri

Dear Ms. Kursh: As a freestanding Home Health Agency we are very concerned about the referral policy which is open for comment at this time.

While technically the patient is being given a choice of which agency receives the referral, we do not feel it is an informed choice. When a patient/family is under the stress of hospitalization, they are very susceptible to nuances and recommendations of the discharge planner. The following situation illustrates my point.

Where Will They Eat?

Characters: Innkeeper, Mr. Miles, traveler, Companion.

Scene: Hotel lobby check-out desk.

Time: 12:00 noon.

Situation: Traveler and companion are checking out of the hotel and anxious to get on their way, but are hungry.

Innkeeper: Thank you so much for staying with us, Mr. Miles. I hope every thing was satisfactory. It is noon and you will be needing lunch soon. Do you have a preference for where you eat?

Traveler: No, but we are hungry and unfamiliar with the area. Pizza sounds good.

Innkeeper: We have an excellent eatery across the lobby. Our chef is Italian and the pizza is superb. We were recently evaluated by Tasters Delight and received a 10 (*Smile*). You can't get better than that! (*Hands traveler a menu.*)

Traveler: Oh, that pizza looks wonderful, but I don't know. We thought we might go down the road a bit. Are there any other places?

Innkeeper: Oh yes, but I can't make a recommendation. You can check the telephone book.

Traveler: Well . . . gee . . . I don't have my reading glasses . . .

(*Innkeeper stands there saying nothing*)

Traveler: Can you just tell me the names of other pizza places?

Innkeeper: Yes, I can, but be sure you understand that I have never eaten at these places and really don't know anything about them, but they are The Pizza Place, Papa's Pizza, and All You Can Eat Family Pizza Place. Now remember, I can't speak about the quality of their food like I can about our restaurant, but you certainly don't have to eat here. The choice is yours.

Traveler: (*Turning to companion*) What do you think?

Companion: Oh, I don't know. It's been a long trip and I'm anxious to get to our destination. I wonder if it really matters.

Innkeeper: Let me reassure you that our restaurant is top quality. I hear lots of great comments from the patrons as they leave. Look on the wall. There is a newspaper article written up just last month.

Traveler: Well, we were certainly pleased with our room so if you say your food is good I guess we better have lunch here.

Scene closes with traveler and companion walking across lobby into the hotel restaurant.

Curtain.

Were the travelers given enough information to make an informed decision? Where would you eat?

I urge you to find these referral policies unacceptable.

Thank you.

Very truly yours,

Cara Kelly,

Administrator.

Metro Home Health Care Services, Inc.

''THE HELPING HANDS OF CARING PROFESSIONALS''

November 27, 1995,

Ms. Gail Kursh,

Chief, Professionals & Intellectual Property, Section/Health Care Task Force, Department of Justice, Antitrust Division, 600 E Street NW, Room 9300, Washington, DC 20530

RE: ''United States v. Health Choice of Northwest Missouri, Inc., et al., Case Number 95–6171–CV–SJ–6

Dear Ms. Kursh: Per the attached:

1. Referring to II B(2): How does the DOJ know that Heartland is an excellent home care agency? A hospital near us opened an agency. We were the best, VNA the second best and theirs was third best. The hospital CEO said all referrals go to the third best agency, their own.

2. Heartland's agency may be the most expensive. PROPAC stated hospitals cost an average of $15.00 more per visit. Should patients be referred to cost effective agencies and not just the one owned by the hospital?

3. Hospitals have been referring to agencies for thirty years. When they start their own agency, do they all of a sudden become deaf and dumb as to what agencies are good and which aren't in their community? Discharge planners' jobs should be to refer patients to quality services regardless of ownership and NOT in regard to how much money the referring entity can make off the referral.

4. Doesn't it seem a bit harsh for the DOJ to suggest that hospitals tell 85 year old sick patients who are quickly being discharged home without support to go to the phone book to find a provider if they don't take the hospital program? Is that giving the patient a choice?

Sick, elderly patients depend on others to give non-biased advice for their care. Please allow that to continue.

Thank you.

Sincerely,

Richard A. Porter,

President/Administrator, Metro Home Health Care Services.

James F. Wayne

Account Executive, Quantum Health Resources, 350 Cordelia Way, Walnut Creek, CA. 94596, (510) 942–0747

November 25, 1995

Ms. Gail Kursh,

Chief, Professionals & Intellectual Property Section/Health Care Task Force, Dept. of Justice, Antitrust Division, 600 E St., N.W., Room 9300, Washington, D.C. 20530

Subject: United States v. Health Choice of Northwest Missouri Inc., et al. Case No. 95–6171–CV–SJ–6 (U.S. District Court, Western District of Missouri)

Invited Comments regarding the above case from the D.O.J. on the proposed final judgment (Ref: Home Health line 11300 Rockville Pike #1100 Rockville MD 20852–3030):

Ancillary Service Referrals

If a patient *does not* accept the provider recommended by their personal physician then the patient shall be referred back to his or her physician to discuss alternatives to make a joint/collaborative decision.

A patient needs to direct his or her concerns about a physician's choice of ancillary service provider and resolve the matter with the physician prior to next step in process. Additional service providers can be discussed and the appropriateness of the additional alternatives can be weighed.

Should the physician and patient disagree with the initial selection, and mutually determine that the chosen provider does not meet the needs of the patient, an alternative provider shall be chosen. The patient shall be redirected to the hospital social worker/discharge planner with the new recommendation.

Timely Ancillary Provider Selection

The physician must enable a patient the opportunity to make a timely and appropriate selection to meet his or her specific needs *prior* to discharge. Should ancillary provider selection be a part of the post-hospitalization treatment strategy then early decisions (e.g. prior to hospitalization) should be considered. This diligence will be mutually beneficial to both physician and patient.

Physician/Patient Collaboration in Provider Selection

A patient with a high-risk chronic disease, for example, one whose needs are unique and potentially multi-system in nature, may require an ancillary service provider with specialized expertise, experience and understanding to meet the highest expectations of quality and safety in caring for that specific disorder. Therefore, *physician/patient collaboration* must take place as a first step in selecting an appropriate provider. Collaboration encourages proactive planning jointly by both hospital based utilization review personnel and families affected by the illness.

Provider Selection Process: Suggested Criteria

1. Clinical specialization in patient's medical condition: The agency rendering the ancillary service shall be recognized by the local medical community as a specialty service with experience and business resources appropriate to the needs of the patient(s) being referred.

2. Accreditation by a joint commission authority: The agency rendering the ancillary service be approved and licensed by a State or Federal agency, i.e., Joint Commission on Accreditation of Home Health Agencies.

3. Physician's ancillary provider selection must be based on ''plan of care'' established to treat and monitor patient's therapy: The referring physician should have a knowledge of the company servicing the patient, including quality of service and abilities of the company to meet all plan of care requirements. A necessary requirement is that the ancillary provider must have *experience and understanding* of the disease state. The selection goal is focussed to match the patient's condition to the service provider's specialty and clinical ability to execute the ''plan of care''.

4. Current ancillary provider shall be notified on admission of their patient by hospital utilization department. Current service providers having relationship with patient shall be given notification that patient has been admitted. Immediate steps can be taken to proactively revise plan of care at expected date of discharge. Home provider will have opportunity to discuss any changed orders with physician and follow the progress of the patient (i.e. concurrent review) until discharge orders are rendered.

Thank you for this opportunity to make comments,

James Wayne

Family Nurse Care

9880 E. Grand River, Suite 110, Brighton, MI 48116, (810) 229–0300

November 21, 1995.

Ms. Gail Kursh,

Chief, Professions and Intellectual Property Section/Health Care Task Force, Dept. of Justice, Antitrust Division, 600 E. St., NW., Room 9300, Washington DC 20530

Dear Ms. Kursh: I am writing to you as the owner of a Medicare certified home care agency and delegate to the White House Conference on Small Business. My agency has serviced Livingston County since 1987, receiving referrals from hospitals in four surrounding counties as well as Livingston County.

In April of this year, the only hospital in the county became affiliated with a multi-hospital organization and our referrals decreased 30%. The Medical Director of this

hospital states that they are mandated to refer to their own hospital-based home health agency. The discharge planners state that they must refer to their own agency. One of our patients asked for our services, presenting a magnet with our telephone number on it and she was refused access to return to our agency. The patient states that she was too sick to argue.

The law is very clear: ''Any individual entitled to insurance benefits under this title (42 USCS 1395 et seq.) may obtain health services from any institution, agency, or person qualified to participate under this title (42 USCS 1395 et seq.) if such institution, agency, or person undertakes to provide him such services''; yet hospitals across the United States are engaged in this practice.

Because hospitals have traditionally lost money over the years, they have targeted home care as an area where they can shift hospital costs and keep the client in a closed system. There are plenty of sick, elderly people in this country and the small, nurse-owned agencies that offer community-based care are being threatened out of existence because of this practice.

I urge you to consider the fact that small businesses are the engine that drives the U.S. economy, and consider the following in your final judgement:

* Bigger is not always better where health care is concerned.
* Set limitations on hospital's ability to refer to clients to their own hospital-based components.
* Require the hospital to use a rotation system, which assures equitable referrals to all providers in the area.
* Require the hospital to permit (on their premises, during normal working hours) representatives of freestanding providers—other than their own hospital-based components—to visit their patients who have been admitted for hospitalization; and to expose the patient population to the availability of outside services as well.
* Make the hospital publicly post its daily referrals to both its hospital-based entities and to other providers in the community.

Sincerely,

Marilyn LeVasseur, M.S., R.N.,

Administrator.

Infusion Management Systems, Inc. dba Concepts of Care

December 1, 1995

Gail Kursh,

Chief, Professions & Intellectual Property Section, Health Care Task Force, Department of Justice, 600 E St. N.W., Room 9300, Washington, D.C. 20530

Re: United States v. Health Choice of Northwest Missouri, Inc., et al. Case No. 95–6171–DV–SJ–6

Dear Ms. Gail Kursh: My name is Sandra Smith Jackson and I am employed as Vice President of the Continuous Quality Improvement Department for a Home and Community Support Agency which has 30 medicare certified agencies across Texas. Our locations are freestanding and we have been providing care for 27 years.

Our Agency will be adversely affected by the proposed final judgment for United States v. Health Choice of Northwest Missouri, Inc., et al. This decision does not encourage fair competition or patient choice. The hospital would be able to monopolize all the ancillary services. Heartland would present information regarding its service without making any mention of other providers in the community unless the patient specifically asked. If the patient asked they would be told to look in the telephone book. I'm not aware of a lot of hospitalized clients that would look for a listing of providers in the telephone book. It would be difficult for a patient who had no preference to make an informed choice if the discharge planner only gives them a brochure for the hospital.

I believe as well as our state association (Texas Association of Home Care) that agencies shall not engage in coercive or unreasonably restrictive exclusionary behavior which would restrict or impede consumer choice of provider agencies. An agency or related entity that provides a screen to clients for home care referrals shall not use that position to influence a client's choice and to direct referrals to itself, and shall inform clients of the availability of home care providers and advise clients that they have the right to choose the provider they prefer. I also believe that agencies should cooperate to see that patient gets the best comprehensive service.

Thank you for allowing me the opportunity to give comments in this matter. I have enclosed a business card if you have any questions.

Sincerely,

Sandra Smith Jackson,

Vice President, CQI/Licensure and Certification.

Visiting Nurse Associations of Pennsylvania

1789 S. Braddock Avenue, P.O. Box 82550, Pittsburgh, PA 15218, (412) 256–6927

November 29, 1995

Ms. Gail Kursh,

Chief, Professions & Intellectual Property Section/Health Care Task Force, Antitrust Division, U.S. Department of Justice, 600 E. Street, N.W., Room 9300, Washington, D.C. 20530

Re: United States v. Heartland Health Systems Inc., Civil Action No. 95–6171–CV–SJ–6

Dear Ms. Kursh: We are writing in support of the letter which you received from VNA HealthCare Services dated November 24, 1995. Visiting Nurse Associations of Pennsylvania is a membership organization which includes 33 community-based, non-profit home health agencies serving the entire state of Pennsylvania.

Our members believe that the ''Referral Policy'' contained in the Final Consent Judgement against Heartland Health Systems Inc. will be used by hospitals to deny patients ''freedom of choice'' of a home health care provider. It is our experience that hospitals steer patients to their affiliated home care agency. This tied relationship restrains our members from competing on a ''level playing field.''

The ''Referral Policy'' in question should be modified to send a strong message to hospitals that they must abide by both Medicare and Medicaid laws and federal antitrust statutes.

Thank you for your consideration of our concerns.

Respectfully yours,

Mahlon Fiscel,

President.

Visiting Nurse Association of Greater Philadelphia

December 1, 1995

Ms. Gail Kursh,

Chief, Professions & Intellectual Property Section/Health Care Task Force Antitrust Division, U.S. Department of Justice, 600 E. Street, NW., Room 9300, Washington, DC 20530

Re: United States v. Heartland Health Systems Inc. Civil Action No. 95–6171–CV–SJ–6

Dear Ms. Kursh: I am writing to urge that the Justice Department not consent to the proposed final judgment in the above-referenced case, because the ''Referral Policy'' regarding provision of home health care does not adequately protect patient choice and fair competition.

The VNA of Greater Philadelphia is the largest home health agency in Pennsylvania. We are a non-profit, community-based agency which has served communities in southeastern Pennsylvania, including the City of Philadelphia, for 110 years. We provide home health services to approximately 2,000 patients a day, many of whom are Medicare and/or Medicaid patients referred for care directly following an episode of hospitalization.

Patient choice and fair competition are protected by both Medicare and Medicaid law and by antitrust provisions. The proposed Heartland referral policy undermines these protections. Heartland would have no obligation to provide reasonable information about other home health providers in the community for patients who have expressed no provider preference. Telling a hospitalized patient that there are other providers listed in the telephone book and then giving the patient ''time to investigate'', all in the context of the Heartland representative extolling the virtues of its home health service, clearly encourages steering patients to the hospital-owned agency. Further, a policy of stonewalling patient's requests for information about other providers, places the discharge planning staff in the position of denying knowledge that they actually have about alternate providers. This clearly undermines continuity of care for patients.

Although the Heartland consent decree may have no formal precedential impact, in practice this decree could have far-reaching, negative impact on patients and on independent providers, including visiting nurse associations, because it would send a clear signal that anti-trust and patient choice protections are no longer to be taken seriously.

We urge that you require a more aggressive policy to assure that vulnerable, hospitalized patients truly have access to the information they need to make an informed choice of their home health provider.

Sincerely,

Stephen W. Holt.

Gardner, Carton & Douglas

1301 K Street, N.W., Suite 900, East Tower, Washington, D.C. 20005, (202) 408–7100, Facsimile: (202) 289–1504

December 1, 1995.

Gail Kursh,

Chief, Professions & Intellectual Property Section, Health Care Task Force, U.S. Department of Justice, Antitrust Division, 600 E Street, N.W., Room 9300, Washington, D.C. 20530

Re: Comments—United States v. Health Choice of Northwest Missouri, Inc., et al., Case No.: 95–6171–CV–SJ–6

Dear Ms. Kursh: The law firm of Gardner, Carton & Douglas is pleased to submit comments in response to the proposed final judgment in the above-captioned case published in the October 3, 1995, Federal Register (60 F.R. 51808). These comments are filed on behalf of an independent home health care company (the ''Company'') located in the Southeast. The Company furnishes over 100,000 home health visits per year and has been in operation since 1985. The Company has four locations and employs over 120 individuals.

During the last three years, the Company has seen many of the hospitals within the Company's service areas promulgate various exclusionary policies favoring referrals of hospital inpatient to hospital-based or hospital-owned home health agencies and other hospital affiliated ancillary providers. Such policies typically prohibit outside agency personnel from hospital floors and encourage discharge planners' referral of hospital patients to hospital providers. The proposed final judgment appears to endorse and encourage such exclusionary practices and, therefore, fails to protect the public interest and should be revised to adequately protect patient freedom of choice and fair competition. The Company comments more specifically as follows:

1. The Proposed Policy Is Contrary to the Public Interest Because It Is Anti-Competitive

While the Company appreciates that the main focus of the underlying litigation in *Health Choice* was not the hospital's referral policies, implementation of the ancillary service referral policy set forth in the proposed final judgment would limit outside providers' and suppliers' access to hospital patients in favor of a hospital's own ancillary providers. That is, the policy, as drafted, would permit and encourage use of the hospital's market power in an exclusionary manner to the detriment of smaller ancillary providers and patients.

Hence, the Company's first concern is that the proposed policy is inconsistent with federal antitrust policy in that it excludes competing ancillary providers from hospital patients. (*See, e.g., Key Enterprises Of Delaware, Inc.* v. *Venice Hospital,* 919 F.2d 1550 (11th Cir. 1990)).

Under Section II(B)(2) of the proposed policy, the hospital may in effect steer patients to its own ancillary providers because it must only inform a patient of alternative providers when hospital services are first denied by the patient. Then, the hospital must only direct the patient to a phone book (Section II(B)(3)) to identify alternate ancillary providers. This system ignores the realities of the hospital-patient relationship, and will unreasonably restrict competition by limiting patient choice. The *Venice* Court noted that ''patients know very little about ancillary providers,'' described a patient's freedom of choice under similar circumstances as ''illusory,'' and concluded that ''[i]t therefore becomes very easy to channel patient choice by limiting the patient's exposure to competition.'' 919 F.2d at 1557. Because the proposed policy grants a privileged status to the hospital's providers, it interferes with fair competition among the range of ancillary providers available to the patients. For this reason, the policy, as drafted, is contrary to the public interest.

2. The Proposed Policy Is Contrary to the Public Interest Because It Violates Patient Freedom of Choice

The proposed policy also is contrary to the public interest in that it violates the freedom of choice provisions of the Medicare statute. Pursuant to section 1802 of the Social Security Act, ''[a]ny individual entitled to insurance benefits under this title may obtain health services from any institution, agencies, or person qualified to participate under this title if such institution, agencies, or person undertakes to provide him such services.'' 42 U.S.C. § 1395a. A parallel provision applies to Medicaid recipients. 42 U.S.C. § 1396a(23).

While this federal ''right to choose'' inures to the benefit of patients (*i.e.,* Medicare beneficiaries and Medicaid recipients) rather than providers, patients denied the option of securing home health and other ancillary care services from any entities other than the hospital's agencies are materially harmed.

The draft ancillary provider referral policy deprives patients of information necessary for a patient to choose among providers and to actively participate in his or her own health care. It also substantially hinders providers' ability to compete for patients based on cost, quality of care, and other objective criteria relevant to a patient's choice. Moreover, as this ''right to choose'' is a fundamental principle underlying the administration of the Medicare and Medicaid programs, denial of such rights by a hospital in accordance with the proposed policy could jeopardize the hospital's status as a Medicare or Medicaid provider.

The Company also notes that the Inspector General (''IG'') of the U.S. Department of Health and Human Services recently deemed hospital self-referral policies as ''suspect.'' As a result, as part of the IG's 1996 Operation Restore Trust Workplan, she will review hospital discharge planning to determine the extent to which financial conflicts of interest, such as hospital ownership of ancillary providers, negatively affects effective hospital discharge planning and patient choice. The Company urges the Department of Justice to coordinate with the IG to develop one consistent policy.

3. Recommendations

Our client agrees that where the patient's physician specifies a particular ancillary provider in the treatment order, that order should be honored, where consistent with the patient's wishes. Also, where a patient expresses a clear preference for a particular ancillary provider, based on reputation, previous experience, health insurance coverage, or other competitive factors, that preference should be honored. However, where neither the physician nor the patient expresses such a choice, the hospital ancillary provider should not enjoy a preferred status over all other ancillary providers. The Company therefore suggests the following revisions to bring the proposed policy within the public interest:

A. Prior to patient discharge, the hospital should be required to furnish to its patients a current list of all certified or otherwise licensed ancillary providers within its service area. Such a list should include the hospital's providers. The hospital need not be charged with responsibility of verifying or guaranteeing the services of listed providers, and appropriate disclosure language may appear on the list.

B. Hospital personnel should not influence, steer or otherwise interfere with patient freedom of choice by directing a patient's referral to (or away from) any particular provider on the list. Independent ancillary providers should be treated the same as the hospital's providers under the policy to prevent the hospital from channeling patients.

C. The policy should clarify that the hospital should continue to permit representatives of nonhospital ancillary providers on its floors, to the extent consistent with patient health and safety, to coordinate the continuing care of referred patients, and to educate physicians and patients of available nonhospital services. The hospital should not block outside ancillary providers' access to physicians, discharge planners, and patients.

D. Last, because the draft policy is largely self-enforcing, the hospital should maintain and make available for public review and verification its records of referrals to ancillary providers.

We are grateful for your consideration of these issues and are pleased to participate in the development of the final judgment. Please do not hesitate to contact me if you have any questions or require additional information.

Very truly yours,

Christopher L. White.

Illinois Homecare Council

Nation's First Homecare Association

November 28, 1995

Gail Kursh,

Chief, Professionals and Intellectual Property Section/Health Care Task Force, United States Department of Justice, Antitrust Division, 600 E Street, N.W., Room 9300, Washington, D.C. 20530

Dear Ms. Kursh: The Illinois Home Care Council is a state-wide trade organization serving the needs of home care providers and suppliers in Illinois. IHCC represents 350 members, including over 250 providers serving more than 125,000 Illinois citizens in their homes. We believe that one of our most

important roles is to speak for the consumers of our services, individuals who, for reasons of age or infirmity, are often unable to speak for themselves.

We are writing to you to express concerns about the proposed consent decree in United States v. Health Choice of Northwest Missouri, Inc., et al., with our attention fixed firmly on the consumers of our services. As a trade organization, our membership includes home health providers of every type: from not-for-profit visiting nurses associations to proprietary chains. We also count among our members many hospital-based home health agencies. Competition is stiff in our state, and sometimes disputes arise among local providers trying to get access to patient referral sources. From that standpoint, we welcome the efforts of the Justice Department to clarify the role of the hospital discharge planner in a facility which offers ancillary services. We also strongly support the need for Medicare recipients, and indeed every home care consumer, to exercise free choice in selecting a home care or other ancilliary service provider.

It is our focus on patients that raises concerns about some of the provisions included in your proposed consent decree, specifically about the Referral Policy presented on page 51812 of the October 3, 1995 Federal Register. We fear that the Justice Department may not fully recognize the speed with which today's patient is admitted to, treated in and discharged from the hospital. Many of these patients are elderly, and are sent home before they and their families have fully grasped what has happened to them and what they will need on returning home. We believe that the process outlined in Part II (3) of the proposed Referral Policy will only serve to increase the anxiety experienced by patients undergoing a hospitalization, and potentially force them into a bad decision. We also doubt whether today's average hospitalization provides sufficient time for the patient to independently examine all of his options and arrive at a conclusion in time for the discharge planner to plan a discharge. In short, we believe that the proposed policy places an unfair burden on vulnerable, sick people. We are unable to see how it protects patient choice or promotes quality care.

IHCC would like to recommend that Part II (3) of the proposed Referral Policy be eliminated and that Part II (2) be amended with a requirement that hospital discharge planning departments maintain a reasonably up-to-date list of licensed ancillary service providers, noting those that are Medicare certified, and that these lists be provided to every patient requiring post-discharge ancillary services. We agree that hospital discharge planners should not be forced into evaluating each provider for the patient; however, they should be aware of the specialities of the various providers, and be willing and able to inform the patients of these specialties. Imparting information about choices is central to the concept of hospital discharge planning. We believe that a focus on the patient and his or her needs will make clear the best policy in this matter.

Thank you for this opportunity to comment on the proposed consent decree. We understand that the proposed settlement technically applies only to the parties involved. However, we also recognize the precedent-setting nature of the acceptance of such an interpretation of the Medicare freedom of choice requirements by the United States Department of Justice. We believe that acceptance of the Referral Policy language currently included in the proposed consent decree will do a grave injustice to hospitalized patients nationwide, and urge you to revise the policy as described above.

Sincerely,

Monica Brahler,

President.

cc: Michael Kulczycki,

Pamela Steinbach,

Rebecca Friedman Zuber

November 3, 1995

Mrs. Marian Wilson,
Tiffany Square Convalescent Center, 3002 N. 18th Street, St. Joseph, Missouri 64505

Dear Mrs. Wilson: Although we have not formally met, I have heard so many good things about you that it seems as though I know you. I know that David Cathcart has talked to you about our interest in acquiring other nursing facilities in St. Joseph, and that you are going to take your time before making any major decision. I have been talking to David about this for nearly a year, and the ''state of the industry'' in St. Joseph has been in a downward spiral during all that time.

Seeing you at the ''Coalition'' meeting tells me that you too are concerned about the future of our businesses. I believe we are at the crossroads of survival today, and suspect that either a facility will close, or an owner will pump large amounts of cash into the business to make it survive * * * for a little longer.

Attached is a copy of a letter to David Cathcart that briefly outlines our thoughts and objectives. I believe it affords you an opportunity to convert your interest into cash, and it affords the new entity an opportunity to make management decisions for the good not only of the nursing homes, but also for the good of the entire community. I cannot imagine the amount of good you have done in this community * * * it has been tremendous. But things in this industry are changing so fast that unless we are changing at the same time, we are falling further behind. The requirement for electronic transfer of MDS data to Jefferson City by next July 1 is one major example. Maybe you are already at that point too, but it took us over a year to become able to do that computer transfer of data. And the new survey process is no cake-walk.

I sincerely hope you will not be offended, and that you will give serious consideration to the content of this mailing. I will be happy to meet with you at any time.

Sincerely,

Lowell Fox,

5051 Faraon 64506, 233–1212 (home), 279–1591 (office).

Central Health Services, Inc.

6600 Powers Ferry Road, Atlanta, Georgia 30339, 404/644–6500

November 28, 1995

Gail Kursh,
Chief, Professions & Intellectual Property Section/Health Care Task Force, U.S. Department of Justice, Antitrust Division, 600 E Street, N.W., Room 9300, Washington, D.C. 20530

Re: *Comments on Proposed Final Judgement: United States* v. *Health Choice of Northwest Missouri, Inc., et al., Case No. 95–6171–CV–SJ–6 in the U.S. District Court for the Western District of Missouri*

Dear Ms. Kursh: As a home health care provider I have first-hand knowledge of the subject matter the Department of Justice is dealing with in the above referenced matter. I also understand the influence a hospital can exert in a patient's selection of post-hospital ancillary services, including the selection of a home health care provider. For these reasons I have reviewed and studied the DOJ's recommended home health, DME and hospice referral policy for Heartland Hospital.

In the interest of protecting patient choice (which is guaranteed by both Federal and State laws) as well as maintaining fair competition consistent with the antitrust laws and FTC regulations, I respectfully submit that the final proposed judgement (recommended policy) be modified as such:

- Strengthen limitations on the hospital's ability to refer its patients to its own hospital-based components;
- Require the hospital to provide patients with an updated list of Medicare/Medicaid providers in the community;
- Require the hospital to use a rotation system, which assures equitable referrals to all providers in the area;
- Require the hospital to permit (on their premises, during normal working hours) representatives of freestanding providers—other than their own hospital-based components—to visit their patients who have been admitted for hospitalization; and to expose the patient population to the availability of outside services as well;
- Make the hospital publicly post its daily referrals to both its hospital-based entities and to other providers in the community.

On behalf of our home health agency and the patients we serve, we respectfully ask that you give these comments due consideration. These issues are of even more concern in today's era of health care and provider consolidation.

Sincerely,

Jerry Sevy,

General Counsel.

Upper Peninsula Home Nursing

1414 W. Fair, Suite 44, Marquette, MI 49855, 906/225–4545

November 22, 1995.

Gail Kursh,

Chief, Professions and Intellectual Property Section/Health Care Task Force, Dept. of Justice, Antitrust Division, 600 E St., NW Room 9300, Washington DC 20530

Dear Ms. Kursh: The only word to describe the DOJ's recent decision in United States v. Health Choice of Northwest Missouri, Inc. et al., is: Devastating.

Private, non-hospital-based home health care agencies already struggle with the monopolistic practices of self-referring hospital programs. This decision would in effect nail the lid on the coffin of informed choice for small community based programs such as ours.

Add in a hospital's ability to divert funds to media advertising and the fact that such advertising is disallowed under Medicare cost settling and you eliminate *any* chance for a private, non-hospital-based agency to establish a level competitive field.

Asking hospital-based discharge planners to ''play fair'' is at best naive, and more likely is simply stupid. When a patient hears a discharge planner state they ''can not speak to the quality of outside providers,'' they will actually hear: ''therefore, the outside program is no good.'' That's reality. Instead, the Department of Justice should be encouraging hospitals to mention ALL agencies who are certified or accredited at the same level, or higher, in their own community.

Let me offer a very good example in our community. For almost twenty years, Marquette County, in Michigan's Upper Peninsula, was served by two private home health care agencies—U.P. Home Nursing & Hospice and Northern Home Nursing. (The area was also served by the small, county-operated health department program.) In 1992, after we refused to sell to the local hospital, Marquette General, the Hospital bought our competing agency.

Instantly, the twenty-year policy of rotating referrals was dropped. Instantly, our hospital-generated referrals went from 45% to less than 4%. Instantly, the U.P. Home Nursing & Hospice discharge planning staff were not allowed to speak to patients in the hospital. In fact, even if a hospitalized patient were already being seen by our Agency, our staff were not allowed to speak to them in the hospital without a signed release, *even if the patient and physician requested us.* Presently, the hospital is telling our patients they are no longer in our care but will have to make their home health decision all over again upon discharge from the hospital. Obviously, the hospital influences their decision toward the hospital's own program.

As a final, and ridiculous, action, the hospital imposed a form on patients that included confusing language. The form compelled them, upon admission, to disavow any non-hospital based home health providers, and this was presented as a normal part of the multi-paged admissions process.

This story is strong evidence that the Department of Justice must include language which addresses the hospital's responsibility to refer to Medicare-certified and accredited programs. U.P. Home Nursing & Hospice has been certified for twenty years through Medicare without a single deficiency. For the past three years, we have maintained accreditation through CHAP—the Community Health Accrediting Program. This sterling accreditation offers us deemed status for participation in Medicare, and we achieved this high accreditation with an unheard of 57 commendations on our first application. For our local hospital to state they can ''not vouch for the quality of this program'' would be utterly unfounded and even fraudulent. They are, indeed, well aware of our high standards of quality. They are also aware of our unique billing policy: for needed home health services, we accept third-party reimbursement as payment in full. Patients are not directly billed. The hospital can not claim this policy and by limiting choice denies care to many in our community who can not afford the hospital's 18% interest rate on unpaid balances.

Your pending decision in the matter of Heartland Health System, Inc. does not include provisions which would protect the private sector. Nor does it support informed choice and anti-trust provisions in the current law. We can understand the DOJ's desire to mandate some type of informed choice for hospital-based programs. At present, it seems there are *none*. But we strongly urge you to consider the modifications proposed by the St. Joseph group, ''Your Right to Choose:''

fl Strengthen limitations on a hospital's ability to refer its patients to its own hospital-based components;

fl Require the hospital to use a rotation system, which assures equitable referrals to all providers *who offer the same level of certification and/or accreditation, or higher* in the area—Hospitals are well aware of the accreditation of local providers;

fl Require the hospital to permit (on their premises, during normal working hours), representatives of freestanding providers.

fl Make the hospital publicly post its daily referrals to both its hospital-based entities and to other providers in the community.

The Department of Justice *must* consider fair competitive practices in this matter. By eliminating freedom of choice, you dilute competition and, thereby, reduce quality and cost-effectiveness in this growing method of health care delivery.

Sincerely,

Cynthia A. Nyquist, R.N., B.S.N.,

Administrator/CEO.

North Woods Home Nursing & Hospice

P.O. Box 307, Manistique, MI 49854–0307, (906) 341–6963, 800–852–3736

November 24, 1995.

Gail Kursh,

Chief, Professions and Intellectual Property Section/Health Care Task Force, Dept. of Justice, Antitrust Division, 600 E. St., N.W., Room 9300, Washington, D.C. 20530

Dear Ms. Kursh: I am writing to you as the owner/administrator of a Medicare certified home health care agency. We have been in operation since 1985. We have had tremendous success with acceptance by our local physicians. I have letters where they laud our service as excellent.

Our regional medical center entered the home health market about 3 years ago and now 2 local hospitals opened agencies in 1994. We have maintained our market share, although our growth has stopped. We looked upon this increased competition with concern, but also as a reason to do a better and better job. We feel competition is good for quality and efficiency.

The referrals from these hospitals and our local doctors has practically dried up. The doctor's office (private physicians) office gives patients a questionable choice situation. The hospital owned physicians and the referral process at the hospital prevents us from receiving referrals, even when the patient requests us. The patients call and tell us they are ''too sick to fight''. This more recent ''bullying'' of our infirm and elderly will surely hamper our continued success.

My optimism of the goodness of people and the upholding of fairness in our judicial system is at question if this present referral practice is allowed to continue. The majority of our patients are served under the Medicare system. Please review the patient rights regulations under this program and also any antitrust implications. I believe the problems here border on basic ''human rights'' exploitation. Referrals should be based on choice *and* a rotating system. Quality issues are assured by MDPH hotline and CHAP certifications, and in our very small town—word of mouth!

Sincerely

Susan L. Bjorne,

Administrator.

Baylor Homecare

3200 W. Hwy. 22, Corsicana, Texas 75110, (903) 872–5535

Lynn Gill, RN

Director of Operations, Baylor HomeCare, 3510 Crutcher Street, Dallas, Texas 75246

Gail Kursh,

Health Care Task Force, Department of Justice, Antitrust Division, 600 E St, N.W., Room 9300, Washington, D.C. 20530

Dear Ms. Kursh: This is a response to the proposed final judgement for United States vs. Health Choice of Northwest Missouri, Inc., et al., Case Number 95–6171–CV–SJ–6 in the U.S. District Court for the Western District of Missouri.

We agree that the referring agency/discharge planner should not make a recommendation for another provider. The discharge planner is familiar with their own facility's home health agency, DME, etc., but not the *many* other agencies available. Many agencies have problems documented by State/Medicare surveyors. These would not be known by the discharge planner. If the patient wants to choose another agency, it is certainly their right. This transfers the liability/responsibility to the patient to research their options and make the choice. If a patient is given a list of providers by the discharge planner and an agency from the list administers poor care, the hospital ultimately could be held liable.

Patient preference should be honored. However, the *physician* also has the right to

refuse to write orders to a certain agency because of a history of poor care, over utilization, etc. Then the patient must then make a choice of either changing physicians or changing agencies.

The proposed referral procedure certainly honors patient choice and guards against liability of the referring facility.

Sincerely,

Lynn Gill, RN,

Director of Operations, Baylor HomeCare.

Danville Regional Medical Center

142 South Main Street, Danville VA 24541
November 28, 1995.

Gail Kursh,
Chief, Professions & Intellectual Property Section/Health Care Task Force, Department of Justice, Antitrust Division, Room 9300, 600 E Street NW., Washington, DC 20530

Re: United States v. Health Choice of Northwest Missouri, Inc., et al., Case No. 95–6171–CV–SJ–6

Dear Ms. Kursh: I applaud the Department of Justice on the recommended home health, DME, and hospice referral policy in the proposed settlement between the department and Heartland Health System, Inc., of St. Joseph, MO.

It is my opinion that the referral policy in the proposed final judgment is fair and equitable. A hospital should have no responsibility to, in effect, promote outside proprietary services with or without a company specific physicians order. Additionally, a hospital cannot be responsible for seeming to tacitly approve of the quality of care provided by outside ancillary companies. If proprietary ancillary service companies wish to enhance their market share, they should do this by making themselves the company of choice by providing outstanding service, not by demanding their name be mentioned immediately upon mention of a home health, DME, or hospice referral.

The policy in the proposed settlement allows for true freedom of choice for patients as it will tend to reduce reliance on company name recognition. It has been my experience that some patients and families tend to select companies with high name recognition even though services provided are unexceptional or even sub-standard.

Once again, I wholeheartedly congratulate the department on it's reasonable, fair, and common sense referral policy.

Very Sincerely,

William S. Sigmon, RN,

Director of Home Health.

Helix Health System

November 28, 1995

Gail Kursh,
Chief, Professions and Intellectual Property Section/Health Care Task Force, Department of Justice, Antitrust Division, 600 E Street, N.W., Room 9300, Washington, D.C. 20530

Re: United States vs. Health Choice of Northwest Missouri, Inc., et al, Case No. 95–6171–CV–SJ–6

Dear Ms. Kursh: I recently saw a copy of the recommended home health, DME and hospice referral policy for Heartland Hospital.

I believe that your recommendation for the approval of this referral policy strikes an appropriate balance between right and obligations of a hospital in connection with its related home health and DME companies. If I had to make any change in the form, it would be to strike out the word ''excellent'' in subparagraph IIB2. I think that the ''puffing'' of its related services is questionable. The remainder of the form is both logical and sensible.

I totally agree with the concept that a hospital should not be placed in a position of having to refer to one or more outside providers. It has no ability to judge the quality or accessibility of the unrelated home health or DME agencies. It does not have the ability, and should not have the obligation, to go through a ''credentialling process'' for the outside agencies. I believe the formula suggested in this document is the only approach that a hospital can reasonably use.

Very truly yours,

Robert J. Ryan,

Vice President & General Counsel.

Center for Health Care Law

519 C Street, N.E., Stanton Park, Washington, D.C. 20002–5809, (202) 547–5262 FAX: (202) 547–7126

December 4, 1995

Gail Kursh,
Chief Professionals and Intellectual Property Section, Health Care Task Force, Department of Justice, Antitrust Division, 600 E Street, N.W., Room 9300, Washington, D.C. 20530

Re: United States v. Health Choice of Northwest Missouri, Inc., et al., Civil No. 95–6171–CV–SJ–6

Dear Ms. Kursh: These comments relate to the proposed Final Judgment, Stipulation, and Competitive Impact Statement that has been filed with the United States District Court for the Western District of Missouri in the above entitled matter, as published in 60 Fed. Reg. 51808 (October 3, 1995). The National Association for Home Care (NAHC), representing the interests of over 6000 home care providers and their patients, recommends several modifications in the proposed referral policy which is designed to ensure patient choice.

Under 42 U.S.C. § 1395a, Medicare patients are guaranteed free choice of a provider of services. That statutory provision provides:

''Any individual entitled to insurance benefits under this title may obtained health services from any institution, agency, or person qualified to participate under this title if such institution, agency, or person undertakes to provide him such services.''

A comparable provision exist under federal Medicaid law, 42 U.S.C. § 1396a(a)(23) which states:

''Any individual eligible for medical assistance (including drugs) may obtain such assistance from any institution, agency, community, pharmacy, or person, qualified to perform the service or services required, * * * who undertakes to provide him such services.''

It has long been the position of the National Association for Home Care that hospitals that participate in the Medicare and Medicaid programs must provide for an unencumbered freedom of choice for post hospital care services as part of meeting their discharge planning obligations. 42 C.F.R. § 482.21(b). In addition, NAHC believes that compliance with the federal antitrust laws requires hospitals and other parties within the health care system to honor a patient's freedom of choice for the selection of care. The proposed referral policy set forth for the above entitled matter is a clear effort to achieve those ends. However, we believe that this referral policy should be strengthened in a number of areas and clarified in others.

The most important alteration that should occur in the referral policy is an expansion of the standard for ancillary services referrals to specifically include an application of the policy to *any party* within the health system that is in the position to affect a referral for services. For example, many patients are referred to home health services from physicians, clinics, nursing facilities, rehabilitation centers, as well as hospitals. The referral policy should clearly state that it applies to all parties within the health system that are in a position to affect a referral.

In addition, the proposed referral policy is designed in a manner which offers true freedom of choice only after the health system is allowed to market its ancillary services to the patient. We would recommend that the referral policy be modified to provide that when an ancillary service has been ordered and a provider specified, the referring person be obligated to inform the patient that he or she does not have to use that provider but may choose any provider he or she wants. Moreover, the referring person should be obligated simultaneously to provide information to the patient regarding the availability of other providers in the community. Similarly, when the doctor has not specified a particular provider and the patient has no preference as to provider, the referring person should be obligated to provide information regarding the availability of other providers in the community. A patient cannot made an informed choice unless such information is provided. The referring person is in a position to provide such information. A patient should not be required to reject the doctor's specified provider or Heartland's ancillary services or ask what other providers are available before the referring person provides information regarding the availability of ancillary services in the community.

In terms of providing information, NAHC recommends that the referral policy be modified to require that the referring person offer a list of available providers which includes, but is not limited to, those providers listed in a telephone book. Specifically, with respect to home health and hospice services, NAHC would recommend that the health system secure an up-to-date listing of certified providers on a quarterly basis and make this list available to patients.

Finally, we are concerned that the referral policy allows for a marketing effort within Heartland that could result in undue influence over an individual's choice of ancillary service providers. Many patients are not aware of alternative providers that may be available in their community. Particularly in an inpatient setting, they are in a captive environment where marketing could result in inappropriate steering or coercing of patients into Heartland's own ancillary service providers. The referral policy should impose some restraints on the marketing activity. That restraint would not require that the health system open its doors to marketing efforts by competing ancillary service providers. Instead, it should focus on the degree of access to the patient by the ancillary service providers or a party within the health system acting on their behalf. Limiting the marketing efforts to an expression of the availability of an accredited ancillary service available to the patient with a brochure should provide a sufficient protection.

NAHC appreciates the opportunity to provide comment on this matter. It is anticipated that the final referral policy will be utilized by health systems and other provider facilities across the country as a basis for determining whether their activities comply with federal antitrust laws. Accordingly, it is advisable that the Department of Justice ensure that it is established in a manner which appropriately and comprehensively achieves patient freedom of choice.

Very truly yours,

William A Dombi

Approve Home Medical Services, Inc.,

2000 E. Harrison St., Suite E, Batesville, AR 72501, (501) 698–1123, (800) 822–8232, Fax (501) 698–1044

December 2, 1995

Gail Kursh,

Chief, Professional & Intellectual Property Section, Health Care Task Force, Department of Justice, Antitrust Division, 600 E St., NW., Room 9300, Washington, DC 20530

Re: U.S. v. Health Choice of Northwest Missouri, Inc., et al. Case No. 95–6171–CV–SJ–6 in the U.S. District Court for the Western District of Missouri.

Dear Ms. Kursh: As I was catching up on my reading of professional journals and newsletters this past week, I happened on to an article in Home Health Line newsletter dated 11–13–95 that disturbed me greatly. I am an owner of an independent free standing home health agency that is currently fighting the unfair discharge practices of our local hospital much as must be the case in St. Joseph, Missouri with Heartland Hospital.

I was totally appalled that the Department of Justice was considering endorsing such a biased and unfair referral policy as the one described in the newsletter article. If approved, this would be a true victory for unscrupulous hospitals bent on totally monopolizing the home health care market in their areas. To think that an elderly person, so ill as to be hospitalized and then met all the criteria for home health care upon discharge, would be in any condition to be put through this proposed maze without just giving up and saying, ''Oh, go ahead and do what you want'' to the discharge planner, is totally naive. No patient would be aware that they have to jump through all these hoops and I doubt seriously that any discharge planner would even bother. At best, it would be the word of a sick, feeble, elderly person against the word of the hospital's paid employees that the hospital had complied.

The only way to ensure fairness when a patient does not have a preference would be for the hospital to be required to rotate referrals among area home health agencies. If a patient wants to explore home health options, then a representative from any of the various area home health agencies should be able to visit and talk to the patient just as the hospital's representative does.

Regardless of what policy is adopted, the one proposed by Health Choice of Northwest Missouri, Inc., is incredibly self-serving and is surely the most unfair and unjust proposal I have seen to date. I beg of you to reject this proposal and take time to develop a plan that would truly insure patient freedom of choice and level the playing field for all providers of home health services.

Thank you for taking time to consider my concerns.

Sincerely,

Steve Bryant

CC: Senator Dale Bumpers,
Senator David Pryor,
Congresswoman Blanche Lambert Lincoln

Powers, Pyles, Sutter & Verville PC,
Attorneys at Law

December 4, 1995

Gail Kursh,

Chief, Professional and Intellectual Property Section/Health Care Task Force, Department of Justice, Antitrust Division, 600 E Street, N.W., Room 9300, Washington, D.C. 20530

Re: Proposed Final Judgment: United States v. Health Choice of Northwest Missouri, Inc., et al. Civil No. 95–6171–CV–SJ–6 (W.D. Mo.)

Dear Ms. Kursh: The Home Health Services and Staffing Association (''HHSSA'') hereby files comments on the proposed Final Judgment, Stipulation, and Competitive Impact Statement in the above-captioned case in response to the invitation for comments published at 60 *Fed. Reg.* 51808 (October 3, 1995).

HHSSA represents more than 30 home care and staffing companies which have nearly 1,600 offices in virtually every state and the District of Columbia which employ more than 300,000 people and provide health care services to more than 750,000 people on any given day.

We believe the proposed Final Judgment is inadequate in that it incorporates a referral policy which is inconsistent with its stated objective of promoting ''patient choice.'' See Referral Policy, I. and II., 60 *Fed. Reg.* at 51812/2–3. Further, we believe that the policy is contrary to 15 U.S.C. §§ 1 and 2 and the Medicare Act.

The portion of the policy that creates the greatest concern is the provision which states that a hospital may promote its own home health agency or hospital-affiliated home health agency without informing the patient that he or she has a choice of other agencies and without informing the patient of the name and contact person for other agencies. The policy thereby permits the hospital to engage in ''steering'' patients to the hospital's affiliated home health agency regardless of the price or quality of the service.

It is this practice of steering home health patients that was condemned in a recent treatise as inconsistent with the pubic policy underlying the antitrust laws, as well as managed care. See *The Importance of Maintaining Competition and Antitrust Enforcement in Health Care Reform* (October 26, 1993) (copy attached). This practice results in the destruction of competition, which results in higher prices, reduced quality, and loss of innovation. *Id.* at 2.

As the treatise points out, ''[s]teering can take many forms, but usually is accomplished by the hospitals not informing the patients of competitive alternatives, by not giving patients the opportunity to select another agency, by refusing to distribute the literature of other agencies, by subtly inducing or coercing staff physicians to order only from the hospital's home care company, [and] by falsely disparaging the quality or services of other agencies * * *'' *Id.* at 17. This steering activity has already resulted in substantial litigation under the antitrust laws. *Id.* at 20.

As the American Bar Association has stated, ''[a]ntitrust enforcement, which promotes consumer choices and welfare while restricting anticompetitive conduct, will be vital to the implementation of health care reform.'' *Id.* at 14. The proposed Final Judgment simply does not promote consumer choice while restricting anticompetitive conduct.

Further, we believe that promotion of consumer choice among providers was one of the foundation principles of the Medicare Act. See 42 U.S.C. § 1395a, which protects the right of any beneficiary to ''obtain health services from any institution, agency or person qualified to participate under this title * * *'' This principle has further been incorporated into an amendment to the Medicare antifraud and abuse laws at § 1128D(a)(2)(C) by § 8105 of the Medicare Preservation Act of 1995, which was passed by Congress on November 17, 1995. That amendment will require the Secretary of Health and Human Services, in establishing safe harbors under the antifraud and abuse laws, to consider the extent to which such action will result in ''an increase or decrease in patient freedom of choice among health care providers.''

Accordingly, we urge that the Final Judgment be revised to require a referral policy which informs all patients of their freedom of choice of providers and provides patients with a list of providers which they may use to exercise this choice.

Sincerely,

James C. Pyles

The Importance of Maintaining Competition and Antitrust Enforcement in Health Care Reform

A Joint Position Paper of the American Federation of Home Health Agencies and the Home Health Services and Staffing Association

October 26, 1993.

I. Executive Summary

The Clinton Administration has released its long awaited health care reform legislative package. The Administration's plan relies upon the concept of ''managed competition.'' States will establish health insurance purchasing cooperatives, known as ''regional alliances,'' to purchase health care goods and services from privately operated networks of health providers and insurers that join together to provide goods and services as a group.

In anticipation of health care reform, hospitals are consolidating and diversifying as never before into larger ''health care systems'' that provide products far beyond traditional inpatient hospital services, including post-discharge goods and services such as home health and durable medical equipment.[1] In some circumstances, particularly where the hospital controls a significant percentage of referrals for a particular service and channels or ''steers'' its patients needing that service to its own provider, serious anticompetitive effects result. Other providers of the service are unable to compete on the merits and thus competition is decreased or destroyed.

Hospital steering of patients to their own home care companies in this situation can have profound anticompetitive effects. It can force other home care companies from the market based not on their prices or quality but rather on the hospital's market power over referrals. The arrangement between the hospital and its own home health agency is a stringent entry barrier, preventing new providers of the service from entering the market. Ultimately, the hospital provider is able to exercise substantial market power without a concomitant superiority in quality and consumers suffer. Prices for home care services increase, quality falls, patient choice is narrowed if not eliminated, and innovation is quashed. Indeed, free-standing providers of home health services and durable medical equipment have brought several antitrust challenges to this precise situation, and studies of physician self-referrals to ventures they own confirm these likely effects.[2]

Providers of health care services, particularly hospitals, now argue that, to make health reform meaningful, they need an exemption, or at least ''more lenient treatment,'' under the antitrust laws. Several bills including an antitrust exemption for hospitals have been introduced in Congress, and the Clinton health reform proposal suggests, incorrectly, that some fine-tuning of the antitrust laws might be appropriate. On the other hand, most knowledgeable and objective observers, including the Section on Antitrust Law of the American Bar Association, have concluded that health care reform will not require any type of antitrust exemption or antitrust ''relief'' for providers.

The recently issued Department of Justice and Federal Trade Commission *Statements of Antitrust Enforcement Policy in the Health Care Area* suggest the same. The *Statements,* while providing clearer guidance to hospitals and physicians about the analysis of particular antitrust-sensitive activities, do not relax the antitrust laws or antitrust enforcement and do not appear to support any type of relaxation. Some may misperceive, however, the timing of the *Statements'* publication and their focus on antitrust enforcement in health care as a signal that health reform legislation justifies some type of antitrust relaxation.

The American Federation of Home Health Agencies (''AFHHA'') and the Home Health Services & Staffing Association (''HHSSA''), two of the leading national associations of home health providers, believe that providing an antitrust exemption or lenient antitrust treatment for hospitals or others under health reform would adversely affect consumers. Especially as hospitals increasingly diversify by providing home health and other non-hospital services, it is important to retain current antitrust constraints and strong antitrust enforcement to help ensure that markets for home health services remain competitive. With an antitrust exemption or ''antitrust relief,'' health care systems will squeeze free-standing home health agencies out of those markets and exercise market power to the detriment of consumers of home health services.

Accordingly, we oppose antitrust relief for health care providers in the context of health care reform or otherwise. We believe that federal health reform legislation should include affirmative provisions ensuring that home care companies and other providers of health care service are able to compete to participate in health plans providing goods and services to health alliances. We believe that for ''managed *competition*'' to exist there obviously must be *competition,* which will require a formal mechanism to prohibit some providers from exercising market power to prevent others from competing. This position statement outlines our reasons, and we welcome the opportunity to explain our position in more detail.

II. The American Federation of Home Health Agencies and the Home Health Services & Staffing Association

The American Federation of Home Health Agencies (AFHHA), formed in 1981, is a national association of approximately 170 Medicare certified home health agencies. It includes many different types of home care providers, such as free-standing agencies, visiting nurse associations, hospital-based agencies, chain agencies, and county agencies. State home health associations, vendors to home health agencies, consultants, and individuals also are members. AFHHA seeks to influence public policy on behalf of home health consumers and its members, and provides its members with technical advice on numerous problems and issues affecting the home health industry.

HHSSA is the only national association representing the proprietary home health and supplemental staffing industry. Founded in 1978, HHSSA now includes approximately 23 member companies with over 1,600 offices and more than 250,000 health care workers. Its purposes include encouraging and promoting greater quality, efficiency, reliability, and safety in the delivery of home health care, improving the services of home health providers to the general public and discouraging enactment of restrictive legislation, regulations, or policies that impede competition or adversely affect the public. In pursuing these objectives and based on its in depth knowledge of the industry, HHSSA frequently comments on important governmental policy issues affecting its members and consumers of home care services.

[1] *See* Facey Medical Foundation, IRS Exemption Ruling, (March 31, 1993) (Doc. 93–4212); Friendly Hills Healthcare Network, IRS Exemption Ruling (January 29, 1993) (Doc. 93–1926); ''Health-Care Firms Face Checkup for Merger Potential,'' *The Wall Street Journal,* C1 (Oct. 12, 1993).

[2] *See. e.g.,* State of Florida Health Care Cost Containment Board, *Joint Ventures Among Health Care Providers in Florida* (1991).

III. AFHHA's and HHSSA's Concerns

A. Introduction

The concerns of AFHHA and HHSSA stem from four interrelated factors: (1) The increasing tendency of hospitals to diversify into home care services using anticompetitive practices, such as ''steering,'' that exclude other home care providers based on the hospitals' power over referrals rather than quality of care considerations, and the resulting adverse effects on consumers; (2) the increasing tendency of hospitals to consolidate and thus increase both the percentage of referrals they control and their power over referrals; (3) the effect that health care reform might have in inducing providers to consolidate and integrate further and to diversify into new services using anticompetitive means; and (4) the efforts of some providers, particularly hospitals, to obtain statutory exemptions from the antitrust laws or more lenient interpretation of the antitrust laws.

Succinctly stated, health care providers need no antitrust relief or exemption. For managed *competition* to achieve its anticipated benefits of lowering costs and prices, increasing quality and services, and improving access, and promoting innovation, there must be *competition.* And for competition to exist, logic, economics, and history show that strong antitrust laws and enforcement are crucial. Accordingly, health care reform must include safeguards, at both the federal and state levels, to ensure that home health agencies, as well as other providers, retain the opportunity to compete based on their prices, quality, and patient satisfaction or choice.

B. The Importance of the Antitrust Laws

The purpose of the antitrust laws is to protect and promote competition as the method by which our economy allocates resources. The Supreme Court has noted that the antitrust laws ''are as important to the preservation of economic freedom and our free enterprise system as the Bill of Rights is to the protection of our fundamental personal freedoms.'' [3] The Court long ago explained that the antitrust laws

> rest on the premise that the unrestrained interaction of competitive forces will yield the best allocation of our economic resources, the lowest prices, the highest quality and the greatest material progress, while at the same time providing an environment conducive to the preservation of our democratic institutions.[4]

For these reasons, strong antitrust laws and enforcement have enjoyed wide bipartisan support throughout their history.

Section 1 of the Sherman Antitrust Act proscribes agreements that unreasonably restrain competition. Section 2 of that statute prohibits sellers from monopolizing, attempting to monopolize, or conspiring to monopolize the provisions of goods and services. And section 7 of the Clayton Act prevents mergers and other types of integration between sellers if the likely effect will be to lessen competition substantially.

The basic concern of the antitrust laws is to prevent businesses from obtaining substantial ''market power'' achieved by means other than competition on the merits. Market power—the ability of sellers to raise prices and reduce quality—both transfers income from consumers to producers (a form of ''economic theft'') and distorts efficient resource allocation by decreasing the amount of goods and services produced.

The antitrust laws condemn the acquisition of market power when it results from conduct that excludes competitors from the market without achieving the values that competition promotes. Thus, for example, a firm cannot use its power in one market to decrease or destroy competition in another market. Yet, that is exactly what happens when hospitals providing home care services use their power over referrals to exclude competing home care services from the market. The consumer, of course, is the loser. He or she may pay inflated prices, receive substandard quality, or, in general, not be able to exercise the choice that the antitrust laws envision. Consumer access to health care services is reduced, and innovation may be stifled.

Because of the indispensable role of the antitrust laws in promoting the welfare of consumers, exemptions from antitrust coverage have always been strongly disfavored.[5] Given the importance of the antitrust laws to a properly functioning economy, those arguing for ''special antitrust treatment'' bear an especially heavy burden of persuasion.

C. Managed Competition

Although the precise form that health care reform ultimately will take remains uncertain, some form of ''managed competition'' seems likely. Under the Administration's managed competition proposal, standard benefits would include home care as an alternative to inpatient care,[6] and thus home care will be an important part of health care reform.

Under managed competition, states will establish one or more ''regional alliances'' that will purchase health care goods and services on behalf of individual businesses and consumers.[7] The theory is that regional alliances will be able to coordinate the purchase of health care services efficiently and to exert some degree of countervailing market power over sellers, resulting in lower prices than could be obtained through purchases by individual businesses. Regional alliances would accept payment from businesses and consumers and offer them an array of health plans from which to choose.

Regional alliances would purchase goods and services from ''health plans.'' These will be integrated delivery systems of providers delivering services and insurers financing these services. All forms of health care goods and services, including hospital care, medical services, home health services, durable medical equipment, and drugs could be integrated into large networks or plans. Ideally, each geographical area would include two or more plans that would compete against one another, based on price, type of reimbursement mechanism (*e.g.*, capitation, fee for service, and the like), quality, array of services, and convenience. Many geographical areas, however, particularly those with relatively sparse populations and perhaps inner-city areas, may be unable to support more than one plan.

Health plans could take several forms. For example, the delivery and financing functions could be completely integrated into a single entity as in a Kaiser-type system. Alternatively, the health plan might finance and coordinate the marketing and delivery of health care services, but contract for their provision with different types of providers. Single health care systems formed by hospitals probably will attempt to become the sole provider of

[3] *United States* v. *Topco Associates,* 405 U.S. 596, 610 (1972).

[4] *Northern Pac. Ry.* v. *United States,* 356 U.S. 1, 4 (1958).

[5] *E.g., FTC* v. *Ticor Title Ins. Co.,* 112 S. Ct. 2169 (1992); *see generally* 1 John J. Miles, *Health Care & Antitrust Law* § 7.01 at 7–2 (1992) (''A cardinal principle of antitrust analysis * * * is that immunity from the antitrust laws is disfavored, primarily because of this nation's commitment to competition as the method by which resources are to be allocated.'').

[6] *See generally* Dana Priest, *Clinton Health Plan Includes Broad ''Standard'' Benefits, The Washington Post,* Sept. 4, 1993, at A1, A16.

[7] *See generally* Rick Wartzman & Hilary Stout, *Clinton Health Plan: Push Competition, Be Ready to Regulate, The Wall Street Journal,* Sept. 13, 1993, at A1.

many types of health care services by diversifying into all areas of health care goods and services and then preventing other firms providing these goods and services from competing on the merits. Enacting an antitrust exemption or relaxing antitrust enforcement would help guarantee this result. Consumers would be the losers.

D. Economic Integration and Managed Competition

In forming health plans, providers, particularly hospitals, will attempt to band together to deal ''more effectively'' with regional alliances. Encouraging this consolidation by relaxing the antitrust laws seems especially ironic since a primary purpose for creating regional alliances is to increase the power of buyers and one goal of managed competition reform is to increase competition among providers. Permitting providers to aggregate their market power through integration would seem to defeat these goals by reducing or eliminating competition among providers and allowing provider conglomerates to neutralize the increased bargaining power of health care purchasers.

Regardless of whether a health plan is a fully integrated single entity or contracts with others for goods, services, or financing, health plan formation might result in several types of economic integration. Two are:

1. Horizontal integration among hospitals, by merger or joint venture, which might achieve efficiencies but which also raises the specter of market power—not only in markets for hospital services but in other markets, including home care, as well;

2. Non-horizontal integration (sometimes called vertical integration or diversification), by unilateral entry, merger, joint venture, or contractual arrangement, by which sellers of one good or service diversify into providing other goods or services.

Both forms of economic integration can generate procompetitive effects benefitting consumers. To that extent, we applaud them, and so do the antitrust laws. Under applicable rule-of-reason antitrust analysis, they are lawful [8] and need no exemption or relief from the antitrust laws. On the other hand, unrestrained integration can have significant anticompetitive effects, in which case it is and should be condemned by the antitrust laws—whether it occurs in the context of health reform or otherwise.

The arguments of some provider groups, namely that the antitrust laws and antitrust enforcement in general should be relaxed to permit what they perceive as beneficial ''collaboration'' and integration through mergers between, and joint ventures among, competing hospitals, are misdirected. We and others see no need for antitrust relief regardless of the form that health care reform takes.[9] Indeed, we believe serious damage to the health care system and consumers would result from relaxation of the antitrust laws.

In general, current antitrust principles and enforcement should permit beneficial integration among health care providers, while prohibiting that which might result in the integrating parties obtaining market power. This is particularly true since almost all types of integration will be tested under antitrust's ''rule of reason,'' which requires a fact-specific analysis of the particular circumstances in which the integration occurs. The antitrust laws are thus ''self-adjusting'' to particular sets of facts and economic circumstances and are sufficiently flexible to accommodate any special characteristics or concerns that health care industries or health reform raise.[10] The enforcement agencies have challenged few hospital mergers,[11] and those they did challenge resulted in hospitals with unusually high post-merger market shares, usually over 50%.[12] The agencies have challenged no hospital joint ventures.

Both the Federal Trade Commission and Antitrust Division have emphasized the importance of strong antitrust enforcement if health reform is to succeed. We agree. It seems clear, for example, that alternative delivery systems, such as health maintenance organizations, could not have developed or generated the procompetitive effects they have without antitrust enforcement against organized resistance to them by provider groups.

In addition, a working group of the American Bar Association, which approached the issue without bias, recently concluded that ''antitrust enforcement should not be a barrier to health care reform. Antitrust enforcement, which promotes consumer choice and welfare while restricting anticompetitive conduct, will be vital to the implementation of health care reform.'' [13] Thus, the group explained that ''[a] blanket exemption from the antitrust laws is, therefore, neither necessary or appropriate. The antitrust laws are not a barrier to health care reform but rather a means of promoting and protecting the more innovative and cost effective mechanisms contemplated by health care reform.'' [14] We agree with this objective assessment.

The concern of some providers that they lack antitrust guidance in planning collaborative activities is more credible but provides no basis for more lenient antitrust treatment or an exemption from antitrust coverage. Rather, the solution to this problem is antitrust guidance for the hospital industry. The Federal Trade Commission and Antitrust Division have done exactly that by issuing their *Statements of Antitrust Enforcement Policy in the Health Care Area* on September 15. The *Statements* explain in detail and in non-legalese how the federal antitrust enforcement agencies analyze transactions such as hospital mergers and hospital joint ventures which pose a risk of violating the antitrust laws. In addition, one state attorney general has issued antitrust guidelines relating specifically to hospital mergers.[15]

Early indications are that the Clinton Antitrust Division will enforce the antitrust laws more aggressively than past administrations.[16] We hope the Clinton Administration has the courage to adhere to the convictions it expressed

[8] *See, e.g., National Bancard Corp.* v. *VISA U.S.A., Inc.,* 779 F.2d 210 (11th Cir.), *cert. denied,* 479 U.S. 923 (1986) (upholding procompetitive joint venture among competitors).

[9] One commentator has accused the hospitals of ''crying wolf'' and talking out of both sides of their mouths when complaining about antitrust enforcement. David Burda, *Mergers Thrive Despite Wailing about Adversity, Mod. Healthcare,* Oct. 12, 1992 at 26.

[10] *Appalachian Coals, Inc.* v. *United States,* 288 U.S. 344 (1933) (noting that antitrust laws have the adaptability of constitutional provisions).

[11] Recent Federal Trade Commission figures indicate, for example, that from 1981 through 1992, the Commission received some 332 premerger notifications of hospital mergers. Of these, it investigated about 14 and challenged three. *FTC Watch,* Sept. 6, 1993, at 3.

[12] *E.g., United States* v. *Rockford Mem. Corp.,* 717 F. Supp. 1251, 1280 (N.D. Ill. 1989), (market share of approximately 72%), *aff'd,* 898 F.2d 1278 (7th Cir.), *cert. denied,* 111 S.Ct. 295 (1990)

[13] ABA Working Group on Health Care Reform, *Antitrust Implications of Health Care Reform* (May 14, 1993) at 2.

[14] *Id.* at 17.

[15] Attorney General of Massachusetts, *Antitrust Guidelines for Mergers and Similar Transactions Among Hospitals* (Aug. 19, 1993).

It is both interesting and telling that neither the Department of Justice and Federal Trade Commission *Statements,* nor the Attorney General of Massachusetts *Guidelines* contain or propose any type of relaxed antitrust rules for hospitals. Rather, both merely provide readable and understandable explanations of how those agencies analyze the potential antitrust ramifications of particular types of conduct.

[16] The recent rescission by the Antitrust Division of the much maligned 1985 *Vertical Restraints Guidelines* is but one example of this. Anne K. Bingaman, Assistant Attorney General, Antitrust Division, ''Antitrust Enforcement: Some Initial Thoughts and Actions'' (Aug. 10, 1993).

initially. It would be a shame for the Administration to back away from its commitment by establishing ''special leniency rules'' for one segment of the economy.[17]

E. Integration Affecting Home Health Patients

The form of integration with the most potential to affect adversely consumers of home health services is that where the hospital or health care system (or several hospitals or health systems together) diversifies into home care and then, while hiding competitive options from patients, ''steers'' those needing home care to its own provider. This can result in substantial anticompetitive effects. The problem is occurring already, and health reform likely will exacerbate it, especially if Congress or the antitrust enforcement agencies embrace antitrust immunity or lenient antitrust enforcement.

The competitive difficulty already faced by many consumers of home health services derives from a simple set of facts. A hospital whose inpatients constitute a significant percentage of home health referrals in an area enters the home health market, either unilaterally, by acquiring an already existing agency, forming a joint venture with an agency, or through a contractual relationship. The hospital then ''steers'' or ''channels'' its patients needing home care at discharge to ''its'' company. It might do this in part to escape the effect of hospital rate regulation by federal or state governments. For example, the hospital may have substantial market power in the market for hospital services that it cannot exercise by raising prices because of fixed DRG payment amounts or state rate regulation. Thus, to evade the effects of rate regulations on its bottom line, it diversifies into other markets with less or no regulation. In these, if it can obtain market power, it can exercise that power by raising prices.

Steering can take many forms, but usually is accomplished by the hospitals not informing patients of competitive alternatives, by not giving patients the opportunity to select another agency, by refusing to distribute the literature of other agencies, by subtly inducing or coercing staff physicians to order only from the hospital's home care company, by falsely disparaging the quality or services of other agencies, or by simply disregarding or refusing to honor the patient's or patient's physician's choice when he or she chooses a home care company other than the hospital's. One requirement for competition to work is that buyers and sellers be informed of their options. In this scenario, however, the hospital creates and exploits an ''informational market imperfection.''

Competitors of the hospital's home health service are ''foreclosed'' from dealing with the hospital's inpatients. If this foreclosure is significant, which is primarily a function of the hospital's importance as a referral source, competing agencies will be unable to obtain sufficient patients to remain in business regardless of the cost or quality of those services. Moreover, realizing that a major source of referrals is ''tied up,'' new agencies will not enter the market; the hospital's conduct raises an entry barrier. Ultimately, as competing agencies are forced from the market, the hospital's agency obtains substantial market power, allowing it to raise prices and lower quality to the detriment of consumers. The freedom of patients to choose is adversely affected, and innovation is stifled. Costs also are likely to increase because the hospital home care company feels no pressure to produce its services in the most efficient manner. Depending on the circumstances, the hospital's actions can violate sections 1 or 2 of the Sherman Act or section 7 of the Clayton Act.[18]

We recognize that the antitrust laws are meant to protect *competition*, not *competitors.*[19] In other words, the concern of the antitrust laws is not with the survival of individual home health agencies but with the effect of their destruction on competition generally. The antitrust laws assume that efficient firms will force inefficient firms from the market. Thus, home health agencies offering high prices or inferior quality or services should expect to fail—both now and under health reform. Competition on the merits weeds out some competitors.

Our home health agencies welcome competition on the merits, which the antitrust laws promote. In the situation presented above, however, there is no competition on the merits and therein, lies the problem. Competitors of the hospital's home care agency are not forced from the market because of their inferiority in relation to the hospital's agency, but rather because of the hospital's ability to control referrals and exploit its patients' lack of information about competing agencies. If integrated health care systems are allowed to gain market power under the guise of a ''health plan,'' they will be able to control patient choice even if the patients are given information about the plan's services because the patients will be ''locked up'' in that particular plan.

The Supreme Court, in a landmark antitrust case last year, recognized that lack of information by consumers could result in a seller exercising market power over them and that this lack of information was an important consideration in determining whether an antitrust violation had occurred.[20] Lack of information (or the cost of obtaining information) reduces the ability of consumers to switch to potentially less costly and better services and thus permits the seller to charge higher prices or provide lower quality than otherwise would be possible. Indeed, the seller need not even have a large market share for this power to result as long as information about competitors can be suppressed.

This scenario is more than idle speculation. At least one antitrust case has challenged a hospital's steering patients needing home health services to its affiliated home health agency.[21] Similarly, a number of antitrust suits have challenged steering by hospitals to their affiliated provider of patients needing durable medical equipment, resulting in three major decisions by federal circuit courts of appeals, all in favor of the plaintiff.[22] Thus, even absent reform, the problem is real, and the loser is the consumer.

The adverse effects on competition in home care markets can be magnified

[17] Some states—most without careful examination—have enacted statutes intended to permit hospitals to ''collaborate'' by merging or entering into market allocation agreements if the arrangement is approved by the state. Hospitals will argue that these activities are protected from the federal antitrust laws by the so called ''state-action exemption.'' Whether the state statutes are sufficient effectively to preempt the federal antitrust laws is an unanswered question at present.

[18] The Federal Trade Commission is investigating a similar factual pattern involving physicians. Physicians who typically refer patients to another facility for particular services related to their practice (such as urologists referring to a lithotripsy center) might establish a joint venture to render the service and then refer all their patients needing the service to their venture. If the joint venture includes most physicians who refer patients for that particular type of service, it will be difficult or impossible for other facilities to compete or new facilities to enter the market. *See generally* Kevin J. Arquit, Director, Bureau of Competition, Federal Trade Commission, ''A New Concern in Health Care Antitrust Enforcement: Acquisition and Exercise of Market Power by Physician Ancillary Joint Ventures'' (Jan. 20, 1992).

[19] *See eg., Atlantic Richfield Co.* v. *USA Petroleum Co.,* 110 S.Ct. 1884 (1990).

[20] *Eastman Kodak Co.* v. *Image Technical Servs., Inc.,* 112 S.Ct. 2072 (1992).

[21] *Beacon Med Care, Inc.* v. *Sound Home Health Servs., Inc.,* No. C84–478T (W.D. Wash. filed Aug. 9, 1984).

[22] *M&M Medical Supplies & Serv., Inc.* v. *Pleasant Valley Hosp.,* 981 F.2d 160 (4th Cir. 1992) (en banc); *Advanced Health Care Servs.* v. *Radford Community Hosp.,* 910 F.2d 139 (4th Cir. 1990); *Key Enters., Inc.* v. *Venice Hosp., Inc.,* 919 F.2d 1550 (11th Cir. 1990) (vacated and rehearing en banc granted).

when hospitals integrate horizontally. Many home care patients are hospital inpatients needing home care services at discharge. When hospitals integrate, by merging, for example, their power over referrals for home health services merges and increases as well. Typically, if both hospitals have home care companies, those companies also merge, increasing their market power in the market for home care services.

The same anticompetitive problem can arise short of merger. For example, competing hospitals might establish, as many have done, a single home care company by forming a home care joint venture. The result may be anticompetitive if, had they not formed the joint venture, the hospitals would have entered the home care market independently or if the hospitals tacitly or explicitly agree to refer their patients needing home care to their joint venture. That type of agreement is analogous to physicians referring patients to joint ventures in which they have an economic interest, which empirical studies have shown increase both utilization and price.[23] Hospital joint ventures formed to provide durable medical equipment have been subjected to antitrust challenge.[24]

The integration that health reform might generate if the antitrust laws are relaxed will exacerbate the competitive problems already experienced in home care markets. The managed competition model will induce hospitals to integrate horizontally as they attempt to negate the effects of health alliance purchasing power. Managed competition also will induce hospitals to diversify—integrate non-horizontally—even further to become the exclusive provider of both hospital services and the full array of health care services to AHPs, including home care.[25] Health care systems, for example, are acquiring physician practices to be able to offer medical services in a package with hospital services.[26] They desire to offer a ''seamless system'' of health care in which the system provides all needed goods and services.

This presents no anticompetitive problem if all providers remain able to compete based on the merits of their products and services, and purchasers have access to the provider offering the lowest quality-adjusted price. Seamless systems, in fact, do have the potential to produce significant efficiencies, particularly by reducing the health plan's transactions costs in contracting with providers. *Seamless systems, however, will not result in lower costs or higher quality if they obtain market power, and thus vigorous antitrust enforcement in the world of managed care will be crucial.* Consumer welfare will depend on the ability of integrated and non-integrated providers to compete against one another.

Hospitals are likely to use the managed competition environment affirmatively to squeeze other home health competitors out of the market, by, for example, ''bundling'' their package of services (which includes home care) such that the price for each service is not discernible and thus comparable. The transaction may resemble or constitute a tying or ''leveraging'' arrangement whereby the health system refuses to sell some services unless the purchaser buys all. Or, if the health system does offer the services separately, it may price its home care at below cost and then cross-subsidize these losses temporarily with profits from other services. It then easily might be able to recoup its losses after competing home health agencies are forced from the market. The result will be higher prices to consumers, lower quality, and little, if any, freedom or choice.

IV. What's the Answer?

The answer to this potential conundrum is both simple and clear: It is imperative both that Congress *not* loosen the antitrust constraints on activities such as these and that health care reform include provisions designed to ensure that services, such as home care, are selected on a competitive basis. The proponents of antitrust relief have failed to make their case, and the dangers from granting relief are manifest.

We will be able to suggest specific strategies to ensure competition after we have seen and analyzed the specifics of the Clinton proposal. We believe, however, that any reform legislation should require that *all providers* be permitted to compete to offer their various services. Statutes or regulations should require, for example, that health plans select providers based on competitive bids or a similar type of competitive process. Regulations could delineate objective criteria for selection based on price, quality, services, and cost effectiveness, perhaps with provisions for appeal when health plans fail to follow competitive procedures.

V. Conclusion

Home health services are a key part of the health care matrix. The industry's importance is growing rapidly as the country seeks better access to less expensive forms of patient care and more types of services can be provided safely in the home. Accordingly, it is important that markets for home health services remain open and competitive, offering patients cost effective, high quality services and continuing innovation. Providing hospitals (or any providers) with an antitrust exemption will inevitably lead to a loss of patient choice, quality care, innovation and effective cost control.

Thus, competition in home care markets is critically important to consumers, providers, and the government alike. That competition should not be needlessly eroded by unwarranted special interest exemption legislation or lenient antitrust enforcement rules that may benefit particular providers but will irreparably damage the health care delivery system and those it serves.

American Federation of Home Health Agencies, 1320 Fenwick Lane, Silver Spring, Maryland 20910, (301) 588–1454.

Home Health Services and Staffing Association, 119 S. Saint Asaph St., #115D, Alexandria, Virginia 22314, (703) 836–9863.

Patient First

Home Health Nursing Services, Inc., 811 West Avenue, P.O. Box 1026, Wellington, Texas 79095–1026

To: Gail Kursh,

From: Monni J. Reed, R.N., D.O.N., Patient First Home Health, Wellington, Texas

Re: Proposed final judgment for United States v. Health Choice of Northwest Missouri, Inc.

As a practicing nurse for the last seventeen years I have observed the emergence of home health from the hospital, Dr's office, and now, home health office point of view.

While working in the Doctors office I saw home health nurses come in with problems, concern and suggestions for their patients care. At that time the local hospital had no home health so the Dr. felt free to admit to an Agency without concern about hospital conflict. I had left the Doctors office and was working in the hospital when it opened it's own home health agency to try to increase revenue to keep its doors open. (This hospital has approx. 30 beds). Every Doctor on staff

[23] The concern over steering of patients by physicians led Congress in the Omnibus Reconciliation Act of 1993, § 13562, amending section 1877 of the Social Security Act (42 U.S.C. § 1395nn), to prohibit physician ''self-referrals'' for certain designated services, including home health services.

[24] *E.g., Alexandria Medical Artrs Pharmacy, Inc. v. Alexandria Health Servs. Corp.*, No. 88–0110A (E.D. Va. filed Feb. 3, 1988 (three hospital durable medical equipment joint venture).

[25] *See generally* Sandy Lutz, *Hospitals Continue to Move Into Home Care, Mod. Healthcare,* Jan. 25, 1993, at 28.

[26] *See generally, Dynamic Diversification: Hospitals Pursue Physician Alliances, ''Seamless'' Care, Hosps.*, Feb. 5, 1992, at 20; *Urge to Merge Strong in Health Care Field, Flint J.*, July 4, 1993.

was expected to refer to the hospital home health. Families and patients were bombarded with literatures stressing the need to use the hospital home health if they supported the ''local community'' and want to help keep the hospital in existence. I witnessed a staff R.N. be terminated because she worked for another home health on her days off. (She'd been with that hospital for 6 to 10 years). After I had left that small town hospital and started working for a home health agency in another small town, I frequently carried lab specimens and Doctor orders to the small hospital in the town I now work. I was very comfortable going into the hospital to visit patients who were already on our home health services. That halted abruptly when this hospital opened their own home health agency. Now, my patients and their families report that while hospitalized, the hospital home health director tries (and sometimes does) to get them to switch to the hospital home health to support the community and keep the hospital open.

This is directly against guidelines but happens every day. Hospital administrators feel they are above the rules and regulations that the rest of us must live by. By passing this bill as it stands we will only be giving them the final go ahead.

Monni J. Reed

Kevin Miller, RRT, RCP

306 Live Oak St., College Station, Texas 77840, Home 409–693–6419, Office 409–774–1198

November 29, 1995.

To: Gail Kursh,

Chief, Professions & Intellectual Property Section/Health Care Task Force, Dept. of Justice, Antitrust Division, 600 E St., N.W., Room 9300, Washington, D.C. 20530

IE; Final Judgment for United States v. Health Choice of Northwest Missouri, Inc., et al., Case #95–6171–CV–SJ–6

Dear Ms. Kursh: I have been a health care professional for many years with most of my employment within hospitals as management or in supervisory positions. This has given me great knowledge of billing practices, accreditation surveys as well as expansion of service projects that include home health and home medical equipment ventures.

The majority of hospitals in the United States commonly overcharge, over utilize service and often provide poor quality of care. The poor quality of care and malpractice are seldom noticed by JCAHO or the general public as these problems are most often covered up or altered to appear to be appropriate care. Most surveys are announced and scheduled. This allows hospitals time to alter paper work and generate reports that indicate they are performing well in the patients best interest. Further most hospital bills are not closely scrutinized and contain a tremendous amount of over billing and or charges for unnecessary procedures and supplies. I am confident that 80–90% of all patient bills are in some way inflated. When over billing is discovered most hospitals simply correct the bill and indicate that there was a billing error. I have noted many of these practices at virtually every hospital I have worked with and is common knowledge among many health care professionals.

In the last few years there have been more and more hospitals ever expanding into home health, home medical equipment, extended care facilities and other areas they feel would profit them. Their position allows them total access to these patients and the ability to self refer them to their affiliates. The patient loses their freedom of choice for health care. Home care services have been available for many years provided by established free standing home health agencies throughout America. These agencies are experts with many years of experience providing home care. They possess great knowledge of the home care field and employ a variety of medical professionals. These free standing agencies for the most part provide good care and have saved tax payers money. It is well understood that home care is by far, less expensive than hospitalization. This cost savings have helped the home care market to grow and have decreased the patients average stay in the hospital. There is currently a large network of free standing home care providers within most areas of our country and there is not a need for hospitals to extend their care in these areas. This would only drive free standing providers out of business and allow hospitals the opportunity to monopolize on every aspect of health care. This move would further burden our entire American health care system and add to the current health care crisis.

There is always a conflict of interest whenever a hospital based provider of home health care is allowed to control all referrals. If the DOJ allows this to happen, they are not protecting the taxpayers interests. It would only benefit hospitals. The ever increasing cost of health care can be attributed to hospitals that exploit their positions and have caused health care spending to increase unchecked. It alarms me to think of the consequences this action would cause and its impact on all Americans. A standard referral procedure should be developed by the DOJ, not Heartland as this will only result in exploitation of patient referrals. I have enclosed information on a recent ruling that should provide guidance for the DOJ. Further hospitals should be limited to prevent monopolistic practices. There is little risk of liability to hospitals if they inform the patient that they are not responsible for non affiliates upon referral.

The final judgement in this case may be viewed as a precedence in future cases that are similar. For this reason great care should be taken to insure that stringent guidelines are in place that govern hospitals referral policies. Further restrictions are needed to prevent hospitals from pursuing ventures that are not in the best interest of the public. It should be clear that hospitals and large health care systems are in a prime position to commit Medicare fraud and abuse. The hospitals that are venturing into home care should be suspect and closely scrutinized to help discourage this abuse.

In closing I would like to thank the DOJ for allowing comments on this case prior to the final judgment. I hope that these comments are helpful in determining this case.

Best Regards,

Kevin E. Miller

American Federation of Home Health Agencies, Inc.

1320 Fenwick Lane, Suite 100, Silver Spring, MD 20910, Phone (301) 588–1454, Fax (301) 588–4732

December 4, 1995.

Ms. Gail Kursh,

Chief, Professions & Intellectual Property Section, Health Care Task Force, Antitrust Division, Department of Justice, Room 9300—600 E Street, N.W., Washington, D.C. 20530.

Dear Ms. Kursh: The American Federation of Home Health Agencies (AFHHA) wishes to comment on the Department of Justice's proposed final judgment in the *United States v. Health Choice of Northwest Missouri, Inc., et al.*, Case No. 95–6171–CV–SJ–6, in the U.S. District Court for the Western District of Missouri. AFHHA is a national association representing Medicare participating home health agencies, the majority of which are free-standing small business providers.

AFHHA contends that the proposed judgement, if finalized, will convey to hospital based entities a strong competitive advantage, blessed by the Department of Justice, which is not equitable to patients, other providers, or the Medicare program. We are pleased that the proposed judgement constitutes an acknowledgement that the patient has the right to receive home health and other services from a provider of his or her choice. Unfortunately, the Department of Justice would allow this right to be easily circumvented by the discharging entity.

The proposed judgement does little to address current monopolistic practices of some hospital networks. Home health providers are experiencing ongoing problems with the refusal of hospitals to refer patients to home care agencies other than their own. This extends to the point of refusing to honor the patient's or family's specific choice of provider and even though the non-affiliated agency may offer a broader range of service and greater access to care, including emergency services.

Our members are Medicare participating, which means that they meet very strict Federal conditions of participation, and are certified as meeting such standards by state surveyors and/or by an accrediting body, i.e., the Joint Commission for the Accreditation of Healthcare Organizations or the National League for Nursing.

The procedures which you outline enable a hospital to cast doubt on the reputation of all non-affiliated home health agencies and ensure that hospital based home care providers will receive virtually all referrals. Giving the hospital the right to hype or puff their ''excellent'' services while disparaging other providers with comments such as ''we cannot make a recommendation,'' ''have done no evaluation,'' and ''cannot speak to the quality of care'' they provide stacks the deck in favor of the hospital and against competing providers.

The judgment also grants an unfair advantage to the hospital's ancillary services by providing that the only source of

information that must be mentioned regarding services offered by independent providers is the Yellow Pages. Referring patients to the Yellow Pages leaves them to perform the legwork to identify other qualified providers. Placed in this position, most patients will simply agree to accept the hospital's ancillary service. Confused, sick, frail elderly patients cannot ''look it up'' in the phone book, even if able to read the print. Nor do families ordinarily have the energy, time, knowledge, or resources to fight for their right to choose a provider at a time when they are tending to a hospitalized family member.

The Department of Justice may in fact end up exacerbating the problem of captive referrals. Hospitals are purchasing physician practices and providers of ancillary services, thereby guaranteeing a steady stream of referrals. We have received many reports that physicians have refused to sign home care orders unless the patient agrees to use the hospital based home health agency and that physicians have told patients to find new doctors if they wish to receive services from non-affiliated providers. For their part, physicians with privileges at, or on staff of, hospitals are often subjected to enormous pressure to channel all referrals to hospital based entities. The Heartland solution does not address such abuses.

AFHHA urges that the judgment be revised as follows, in the interest of curbing monopolistic practices, promoting competition, and preserving the small business infrastructure:

1. Hospital discharge planners must demonstrate knowledge of available resources and providers in the community, and assist the patient in making contact, if requested.

2. Patients requiring post hospital home health services must be provided with a written alphabetical list of all duly certified providers in the area, along with phone numbers.

3. Along with the written list of providers, the hospital must distribute brochures supplied by home health agencies in the area.

4. The hospital must indicate the types of services offered by each listed agency, what hours services are available, and whether the home care provider is certified to participate in the Medicare program by the state or by an accrediting body. (Brochures supplied by providers could also serve this purpose.)

5. Hospitals may not arbitrarily omit providers from the list.

6. The patient's choice of provider must be honored. Referrals of patients who indicate no preference must be made on a rotating basis to those home health agencies which offer the range of services ordered by the physician.

7. The referring hospital must disclose any financial relationship with providers on the list supplied to patients.

8. The discharging hospital must obtain written acknowledgement from patients and/or family members that they have received the required information.

9. Referring hospitals must establish a grievance procedure for use by any patient or provider who believes that their rights under this judgment or under Medicare law have been violated. Any such grievance must be heard by a neutral mediator within five business days of the alleged violation.

These changes we recommend will help preserve competition. It was robust competition that enabled the home health infrastructure to respond to the challenge of the 1982 implementation of the Medicare Diagnostic Related Group reimbursement system for hospitals. This reimbursement change led to the earlier discharge of patients from hospitals. Home health agencies have implemented continuous quality improvement programs, developed technological and service innovations, and bent over backwards to satisfy the consumer of home care services. Where home health providers are guaranteed a steady stream of referrals by virtue of steering of patients by a parent hospital, the quality, innovation, and consumer satisfaction associated with a competitive system will be greatly compromised.

With Congress looking at competitive markets as a big part of the solution to what ails publicly funded health care programs, this is not the time for the Antitrust Division to enfranchise one model—the hospital based model—as the prime deliverer of home care in communities across the nation.

Sincerely yours,

Ann B. Howard,

Executive Director.

NAMES

National Association for Medical Equipment Services

December 4, 1995.

Ms. Gail Kursh,

Chief, Professions & Intellectual Property Section, Health Care Task Force, Department of Justice, Antitrust Division, 600 E Street, NW, Room 9300, Washington, DC 20530.

Dear Ms. Kursh: The National Association for Medical Equipment Service (NAMES) hereby submits comments on the proposed consent order in United States v. Health Choice of Northwest Missouri, Inc., et al., Case No 95–6171–CV–S1–6 (W.D. Mo.).

NAMES is a nonprofit association of over 1800 suppliers of home medical equipment (HME) and services, in approximately 4000 sites across the country. Based upon individual patient needs and according to physicians' prescriptions, NAMES members furnish a wide variety of equipment, supplies, and services for home use, from traditional medical equipment such as oxygen and hospital beds, highly sophisticated items and services such as parenteral and enteral nutrition and supplies and specialized wheelchairs. NAMES member companies include both ''freestanding'' independent HME entities and those with hospital affiliations, either through ownership or contractual arrangements.

NAMES is concerned with those provisions of the proposed settlement involving Heartland Health Systems Inc., which set forth the hospital's obligations when referring patients to hospital-affiliated ancillary service providers, including its HME supplier. DOJ's focus in the case was on a separate issue—collusion with physicians—and the ''patient referral to affiliated companies'' aspect of the hospital operation necessarily constituted a smaller part of the agency's scrutiny. NAMES is concerned, however, that these provisions of the final agreement (Section II, entitled ''Ancillary Service Referrals'') may be viewed as setting a standard for the industry for hospital-owned or affiliated HME providers.

Referrals by a hospital to an affiliated ancillary service provider give rise to numerous regulatory issues relating to patient freedom of choice, including whether full disclosure of the affiliation has been made to patients and whether the patients, in turn, have provided informed consent to receive services from the affiliated provider. NAMES' Code of Ethics addresses this issue specifically, providing at paragraph 9 that HME suppliers must:

> *avoid participating, directly or indirectly, with a source of patient referrals in a ''captive referral arrangement'' whereby patients are directed to utilize a supplier of home medical equipment in derogation of the patients' rights to select the supplier of their choice.*

Some NAMES members have expressed the view that the proposed policy—which does not require the hospital having an affiliated ancillary service provider to inform the patient of other area suppliers—does not ensure informed patient consent and freedom of choice.

Given the complexity of the issues involved, and the fact that this aspect of the settlement did not constitute DOJ's primary focus in this case, NAMES recommends that the DOJ clarify the proposed order to make clear that if it is not intended to establish an industry standard. Alternatively, DOJ should furnish a more detailed explanation of the competitive factors which it considered in accepting the hospital's proposal in this case.

Overall, NAMES believes that an effort to articulate standards for hospital referrals to affiliated HME suppliers would be beneficial. The adoption of clear, objective standards would do much to reduce or eliminate the multiple disputes which have arisen in this area.

Please do not hesitate to contact us with any questions.

Sincerely,

William D. Coughlan,

President and CEO.

NAMES

National Association of Medical Equipment Suppliers

CODE OF ETHICS

Having been accepted into membership in the National Association of Medical Equipment Suppliers, we do hereby subscribe without reservation to the Association's Code of Ethics.

The purpose of the Code of Ethics shall be to set and improve standards within the practice of providing home medical equipment and services. To maintain the ethical conduct and integrity of this Association, a member pledges to abide by the following:

1. To render the highest level of care promptly and competently taking into account the health and safety of the patient.

2. To serve all patients regardless of race, creed, national origin or reason of illness.

3. To provide quality home medical equipment and services which are appropriate for the patients' needs.

4. To instruct the patients and/or caregivers in the proper use of the equipment.

5. To explain fully and accurately to patients and/or caregivers patients' rights and obligations regarding the rental, sale and service of home medical equipment.

6. To respect the confidential nature of the patients' records and not to disclose such information without proper authorization, except as required by law.

7. To continue to expand and improve professional knowledge and skills so as to provide patients with equipment and services which are continually updated.

8. To abide by both Federal and local laws and regulations which govern the home medical equipment industry.

9. To avoid participating, directly or indirectly, with a source of patient referrals in a ''captive referral arrangement''; whereby patients are directed to utilize a supplier of home medical equipment in derogation of the patients' rights to select the suppliers of their choice.

10. To act in good faith; to be honest, truthful and fair to all concerned.

Gibson Health Services

1468 State Street, P.O. Box 368, East St. Louis, IL 62202, (618) 274–6026

December 4, 1995.

Ms. Gail Kursch,

Chief Professions & Intellectual Property Section, Health Care Task Force, Department of Justice, Anti-trust Division, 600 E. Street, N.W., Room 9300, Washington, DC 20530.

Re: United States v. Health Choice of Northwest Missouri, et al, Case No. 95–6171–CV–SJ–6, United States District Court for the Western District of Missouri.

Dear Ms. Kursch: I understand that you are accepting comments on the proposed settlement for the above referenced case.

I feel that it is not only unjust but also inhumane to condone, endorse or approve a policy or settlement that allows a discharge planner to give a patient a telephone book unless the patient asks a second time instead of a list of area Home Health Agencies.

My staff and I would like for you to consider the following regarding the Department of Justice's recommended Home Health Referral Policy:

1. It represents a discriminatory act against a person who is illiterate or who has a limited reading and/or mental capacity.

2. If the patient cannot read or has a limited mental capacity, this denies the patient their right to make an *informed* decision.

3. Depending upon the community the hospital is located, the phone book may not list all of the agencies that provide services where the patient lives. For example, if this patient lives in East St. Louis, Illinois and was in a St. Louis, Missouri hospital (which is common) and is given a St. Louis, Missouri phone book, my agency in East St. Louis would never be recognized.

4. It reflects a blatant kickback violation because the ''intent'' is merely to increase the hospital's revenues. Does the hospital have its own ambulance service? transportation service? private duty service? home oxygen service? etc.? If not, how is the patient made aware of their option for these services? If options are offered for services that they do not provide, sounds like something is really wrong not to do the same for services they do provide.

5. While we can clearly understand that a hospital may not want to ''endorse'' other Home Health Agencies, providing a list of available agencies could be beneficial to everyone. The patient is conveniently given information for decision making, the free standing Home Health Agency is fairly recognized and the hospital has a better working relationship with the Home Health Agency which helps everyone.

6. The hospitals could simply provide a list of agencies by name, address, phone and area served. It would be ideal to also include the disciplines and specialties offered by the agency. The hospital Discharge Planner could then read off the list of agencies serving the patient's community. A senior citizen or person with limited reading ability might recognize the name of an agency he or she is familiar with. In addition, many persons prefer to support agencies within their community. This is particularly important in minority communities where there may be a strong ethnic consciousness to support their own minority businesses to help with jobs, taxes, etc.

7. It's simply more convenient for the patient. Patients are now leaving the hospital in more acute states. If you were sick, would you want to try to find something in the Yellow Pages that you knew nothing about?

8. If this hospital is only going to give the patients a phone book and the sick person says ''That's OK, I don't feel like looking through a phone book,'' will the hospital's Home Health Agency follow *all* patients that are discharged from the hospital?

- The patient with no coverage?
- The patient that lives in the high crime areas?
- The patient that travelled a long distance to this hospital who lives perhaps 50 miles or more away??
- The patient on Medicaid (The significance of this will vary from state to state. Some states reimburse cost while other states reimburse well below cost. For example, in Illinois, Medicaid only pays $41.55 per visit without consideration that the cost is $55 to $75 per visit.)

In summary, we would recommend that Sections II.B.2 and II.B.3 of the attached recommended policy be removed to reflect that a list of area Home Health Agencies are read and given to the patient which includes the hospital's home health agency. The hospital could note that they are not endorsing the other agencies, but stress that the information is given for them to make the choice. The patient/family should be offered the time, if desired, to call some of the agencies if they want more information.

If I can be of further assistance in this matter, do not hesitate to call. Thank you for your attention.

Sincerely,

Patricia A. Gibson,

Chief Executive Officer.

C: National Association of Home Care, Illinois Home Care, Council

Law Offices, Small, Craig & Werkenthin, A Professional Corporation

Suite 1100, 100 Congress Avenue, Austin, Texas 78701–4099, (512) 472–8355, San Antonio Office, 300 Convent Street, Suite 1950, San Antonio, Texas 78205–3738, (210) 226–2080, Facsimiles, Austin: (512) 320–9734, San Antonio: (210) 226–2646.

December 1, 1995.

Ms. Gail Kursh,

Chief, Professions & Intellectual Property Section/Health Care Task Force, Department of Justice, Antitrust Division, 600 E St. N.W., Room 9300, Washington, DC 20530, VIA FAX NO. (202) 514 9978.

Re: Comments on Proposed Final Judgment; *United States v. Health Choice of Northwest Missouri, Inc., et al.*, Case No. 95–6171–CV–SJ–6; In the U.S. District Court for the Western District of Missouri.

Dear Ms. Kursh: This law firm represents Texas Home Health, Inc. which is a home health care provider in Texas. With respect to the Proposed Final Judgment in the above matter, Texas Home Health submits the following comments.

The referral procedure developed by Heartland Health System would allow Heartland to maintain a competitive advantage over other providers in the situations in which the patient does not have a provider preference. Under Heartland's proposal, if the patient does not have a preference, the discharge planner is allowed to inform the patient that Heartland has the capability to provide the services and apparently would be allowed to make representations as to the quality of service to be provided. If the patient does not accept Heartland's services, it appears that the patient would be given a telephone book and informed that there are other providers for which quality representations cannot be made.

If this procedure is followed, it is unlikely that any provider other than Heartland would receive referrals. Apart from the fact that Heartland would be in a position to embellish quality and provide tacit indications that it is preferable to other providers, if a patient has no preference as to providers, the patient will more likely than not choose Heartland because it has no other information about the other providers. The patient would be forced to locate other providers in a telephone book and make its own investigation. It is unlikely patients will expend this effort. Additionally there may be a perception that the other providers do not provide services having the same degree of quality as Heartland.

To correct these deficiencies in the proposal, the discharge planner should

provide the patient with the names of every provider that has requested to be included on the information listing. No preference should be given to Heartland, and the same type of information should be given for each provider. Heartland should be precluded from making oral representations about its services or implying that its services are superior to those of other providers unless other providers are given the opportunity to make similar presentations.

Other providers should be given the opportunity to have brochures distributed to the patients. The essence of the procedure should be to ensure that the patient has freedom of choice and that Heartland cannot exploit its position to give it a competitive advantage. Heartland's proposal will not accomplish this.

Only if all providers participate on a level playing field can freedom of choice truly occur. All providers should be given the opportunity to be included on a listing of eligible providers and to provide information that can be evaluated by the patient without influence from the discharge planner. Otherwise, the discharge planner could effectively control the patient's decision or provide information in a favorable light to Heartland. The effect of this is that other providers are precluded from having the opportunity to market their services to potential consumers.

Texas Home Health respectfully requests that you consider the potential abuse with the proposed referral procedure.

Very truly yours,

William R. McIlhany

Central Home Health Care

Decatur Office, 495 Winn Way Suite 100, Decatur, Georgia 30030, 404/296–0805.

November 29, 1995.

Gail Kursh,

Chief, Professional & Intellectual Property Section/Health Care Task Force, Department of Justice, Antitrust Division, 600 E. Street, N.W., Room 9300, Washington, D.C. 20530.

Re: *Comments on Proposed Final Judgement: United States v. Health Choice of Northwest Missouri, Inc., et al., Case No. 95–6171–CV–SJ–6 in the U.S. District Court for the Western District of Missouri.*

Dear Ms. Kursh: As a home health care provider I have first-hand knowledge of the subject matter the Department of Justice is dealing with in the above referenced matter. I also understand the influence a hospital can exert in a patient's selection of post-hospital ancillary services, including the selection of a home health care provider. For these reasons I have reviewed and studied the DOJ's recommended home health, DME and hospice referral policy for Heartland Hospital.

In the interest of protecting patient choice (which is guaranteed by both Federal and State laws) as well as maintaining fair competition consistent with the antitrust laws and FTC regulations, I respectfully submit that the final proposed judgement (recommended policy) be modified as such:

- strengthen limitations on the hospital's ability to refer its patients to its own hospital-based components;
- require the hospital to provide patients with an updated list of Medicare/Medicaid providers in the community;
- require the hospital to use a rotation system, which assures equitable referrals to all providers in the area;
- require the hospital to permit (on their premises, during normal working hours) representatives of freestanding providers—other than their own hospital-based components—to visit their patients who have been admitted for hospitalization; and to expose the patient population to the availability of outside services as well;
- make the hospital publicly post its daily referrals to both its hospital-based entities and to other providers in the community.

On behalf of our home health agency and the patients we serve, we respectfully ask that you give these comments due consideration. These issues are of even more concern in today's era of health care and provider consolidation.

Sincerely,

Sandy Caroland,

Administrator.

Healthfield Services of Middle Georgia, Inc.

2490 Riverside Drive, Macon, Georgia 31204, 912/743–5769.

November 29, 1995

Gail Kursh,

Chief Professional & Intellectual Property Section/Health Care Task Force, Department of Justice, Antitrust Division, 600 E. Street, N.W., Room 9300, Washington, D.C. 20530.

Re: *Comments on Proposed Final Judgement: United States* v. *Health Choice of Northwest Missouri, Inc., et al., Case No. 95–6171–CV–SJ–6 in the U.S. District Court for the Western District of Missouri.*

Dear Ms. Kursh: As a home health care provider, I have first-hand knowledge of the subject matter the Department of Justice is dealing with in the above referenced matter. I also understand the influence a hospital can exert in a patient's selection of post-hospital ancillary services, including the selection of a home health care provider. For these reasons, I have reviewed and studied the DOJ's recommended home health, DME and hospice referral policy for Heartland Hospital.

In the interest of protecting patient choice (which is guaranteed by both Federal and State laws) as well as maintaining fair competition consistent with the antitrust laws and FTC regulations, I respectfully submit that the final proposed judgement (recommended policy) be modified as such:

- strengthen limitations on the hospitals ability to refer its patients to its own hospital-based components;
- require the hospital to provide patients with an updated list of Medicare/Medicaid providers in the community;
- require the hospital to use a rotation system, which assures equitable referrals to all providers in the area;
- require the hospital to permit (on their premises, during normal working hours) representatives of freestanding providers—other than their own hospital-based components—to visit their patients who have been admitted for hospitalization; and to expose the patient population to the availability of outside services as well;
- make the hospital publicly post its daily referrals to both its hospital-based entities and to other providers in the community.

On behalf of our home health agency and the patients we serve, we respectfully ask that you give these comments due consideration. These issues are of even more concern in today's era of health care and provider consolidation.

Sincerely,

William H. Hursey,

Administrator.

Date: November 29, 1995

To: Gail Kursh, Department of Justice, Washington, D.C.

Re: The final judgement for United States v. Health Choice of Northwest Missouri, Inc. Case #95–6171.

I support the referral procedure Heartland Health System developed for home health, DME and hospice services.

If a physician specifies the provider to be used, ancillary services continue to be medically directed. This prevents the physician or facility from incurring any liability by selecting providers through rotation or otherwise without credentialling or quality assurance procedures. The patient should be asked if this is acceptable, and if so, referred to that provider.

The patient's preference should always be honored if the physician does not order a specific provider.

Agencies should honestly and conscientiously cooperate in providing information to assure comprehensive services to clients and their families.

It has been my experience, hospice services are not as competitive as home health because of the profits involved. The number of home health agencies has escalated dramatically this last year. I am saddened, because I see home health becoming ''big business'' and not a community service any longer. Agencies within our service area have always respected each other and provided service for our individual communities. Many of the newer for-profit agencies do not follow the Medicare guidelines. Some agencies tell their patients that they may drive and never address safety or interim care needs for fear of losing a patient.

Heartland Health Systems has developed a referral system that keeps home health and hospice medically directed and holistic in nature, the way it was intended.

Sincerely,

Reneah Wilson,

Home Health/Hospice Director, Ochiltree Hospital District, 2402 South Main, Perryton, Texas 79070.

Shannon Medical Center

Home Health Services, 120 E. Harris, San Angelo, Texas 76902, (915) 6533–6741

November 27, 1995.

Gail Kursh,

Chief, Professions & Intellectual Property Section/Health Care Task Force, Department of Justice, Antitrust Division, 600 E. St., N.W., Room 9300, Washington, D.C. 20530.

Dear Ms. Kursh: As a hospital-based provider of home care services, I am in favor of the proposed final judgment in the United States vs. Health Choice of Northwest Missouri, Inc. et al., Case No. 95–6171–CV–SJ–6. I find the requirements set out for referrals determination quite satisfactory in assuring patient choice and maintaining competition. Contrary to popular beliefs, hospital-based home care agencies do not have a monopoly on referrals and many of us do our utmost to provide patient choice and are very conscientious in maintaining the Medicare Conditions of Participation. I strongly encourage the judgment to stand and for the Department of Justice to resist placing any additional burdens on providers which would be unnecessary.

Thank you for your consideration.

Yours truly,

Janis Fuchs,

Director, Shannon Home Health Services, 127 E. Beauregard, San Angelo, Texas 76903.

Keweenaw Home Nursing & Hospice

414 Hecla Street, Laurium, Michigan 49913, Fax: (906) 337–9929, 1–800–594–7053, (906) 337–5700

December 1, 1995.

Gail Kursh,

Chief Professions & Intellectual Property Section/Health Care Task Force, Dept. of Justice, Antitrust Division, 600 E. St., NW, Room 9300, Washington, DC 20530.

Dear Ms. Kursh: As an owner of a small rural free standing home health care agency, I have real concern about the recent DOJ ruling in the matter of U.S. v. Health Choice of Northwest Missouri, Inc.

Our agency has an excellent reputation for quality in our community. In over 6 years of existence we have been Medicare certified without a single deficiency. For nearly 3 years, we have maintained CHAP accreditation through the community Health Accreditation Program of the National League for Nursing.

The two local hospitals have teamed together and created their own home care agency. To some degree these hospitals give patients choice but certainly will not continue to give choice under the DOJ ruling. These hospitals are very aware of our quality and reputation and certainly could ''speak to the quality'' of our program.

Please reconsider the DOJ's decision in the case and protect the individuals freedom of choice. The future of the free standing agency depends on it.

Sincerely,

Diane Tiberg

Visiting Nurse Services of Southern Michigan, Inc.

311 East Michigan Avenue, Suite 200, Battle Creek, Michigan 49017–4939, Battle Creek (616) 962–0303, Coldwater (517) 279–7550, Albion (517) 629–8100, Toll-Free 1–800–622–9822, FAX (616) 962–8810

November 28, 1995.

Gail Kursh,

Chief Professional and Intellectual Property Section, Health Care Task Force, Department of Justice, Anti Trust Division, 600 E. St. NW, Room 9300, Washington, D.C. 20530.

Dear Mrs. Kursh: We are writing to give input in the case, United States v. Health Choice of Northwest Missouri, Inc, et al; case number 95–6171 CV–SJ–6 in the U.S. District Court for the Western District of Missouri.

We are a non-profit home care agency serving Southwest Michigan. We wish to urge that hospitals be required to continue to offer patients choices for care so that the value of the free market can continue to influence quality. Patients need to be able to judge and select based upon quality. Monopoly influence often tends to rule out this free choice.

We propose that the final judgment be modified to:

- Strengthen limitations on the hospital's ability to refer it's patients to it's own hospital-based components;
- Require the hospital to use a rotation system, which assures equitable referrals to all providers in the area;
- Require the hospital to permit (on their premises, during normal working hours) representatives of freestanding providers—other than their own hospital-based components—to visit their patients who have been admitted for hospitalization; and to expose the patient population to the availability of outside services as well; and,
- Make the hospitality publicly post it's daily referrals to both it's hospital-based entities and to other providers in the community.

Please consider this as the final judgment is made. Thank you.

Sincerely,

Judy Hoelscher,

Vice President of Clinical Services.

Visiting Nurse Association of Martin/St. Lucie County, Inc.

2400 S.E. Monterey Road, Suite 100, Stuart, Florida 34996, (407) 286–1844, All Areas 930–6877, Joint Commission on Accreditation of Health Care Organizations

November 28, 1995.

Gail Kursh

Chief, Professions & Intellectual Property Section, Health Care Task Force, Department of Justice, Antitrust Division, 600 E. St. N.W. Room 9300, Washington, D.C. 20530.

Re: United States v. Health Choice of Northwest Missouri, Inc., et. al. Case No. 95–0171–CV–SJ–6.

Dear Ms. Kursh: The proposed final judgement for U.S. v. Health Choice is a step back for quality care in the home health care setting. Competition supports and promotes a high quality of care, evidenced by clinical outcomes, cost-effective clinical guidelines, patient satisfaction and appropriate use of community resources. Your proposed judgement has the potential to create a monopoly for hospital-based home health care agencies and may end competition in home health care.

Hospitals have a ''captured audience'' of vulnerable patients who feel dependent upon the hospital staff. Patients are not likely to go against a discharge planner's referral to the hospital home health agency for fear that their failure to ''cooperate'' may create an environment where the patient's continuing needs (in-patient needs and paperwork for reimbursement needs) may not be met or may be delayed.

Additionally, hospitals exert their influence over physicians (with hospital privileges) to refer only to the hospital-based agency in order to support the hospital. Some hospitals have even moved their home health agency from being a separate entity to a hospital department, so that self-referrals are not subject to GAO investigations instituted by Rep. Pete Stark (D–Calif.). A second reason is to shift administrative costs under the present MEDICARE Cost Reimbursed Home Health System.

Over the past two years hospitals discontinued the referral rotation system; discontinued hospital access to patients by agencies who serve them, refer only to their own agencies, called physicians to ask why a hospital patient was referred to an outside agency, etc. These actions clearly demonstrate a move to a monopoly system.

Hospital arguments for promoting their own agency at the exclusion of outside agencies include continuum of care, referrals to other agencies would require hospital credentialing of outside agencies, and hospitals always give the patient a choice. It is easy to refute these claims.

The traditional continuum of care has always been from organization to organization, be it a hospital or other community resource agency, with patient information transferred between professionals who are trained to focus on continuity and coordination of care. Just because a home health agency has the same name or is affiliated with a hospital does not, in itself, assure a continuum of quality care.

The responsibility of a discharge planner includes knowledge and judgement regarding all home health care community resources that would benefit the patient. Discharge planners know resources available and receive feedback regarding the quality of care from these resources. Many state home health agency licensure laws establish standards that agencies must meet, so hospitals know that standards are met and don't need to ''credential'' them. Additionally, many home health agencies today are accredited themselves through either the Joint Commission on the Accreditation of Health

Care Organization (JCAHO), or the Community Health Accreditation Program (CHAP).

Finally, hospitals ALWAYS state they give the patient a choice, yet many patients have told outside agencies that during their hospitalization, hospital representatives have almost insisted they use a hospital-based agency. Also, physicians who refer to outside agencies tell outside agencies that as soon as the patient is admitted, before the physician even discusses discharge with the patient (to advise them of options), the hospital-based agency has already been in to talk with the patient and already has them signed up as a referral for their agency.

Thank you for the opportunity to send my comments on your proposed final judgement for the above mentioned case. Please don't be persuaded by big hospital corporations and hospital lobbyists to pass a judgement that quite probably abolishes competition in home health care and effectively gives patients *no choice.*

Sincerely,

Robert J. Quinn,

Director of Operations.

Cornerstone Home Health Care

6300 Samuell Blvd., Suite 120 B, Dallas, Texas 75228–7100, Phone: (214) 681–1600, Fax: (214) 381–2900

Gail Kursh,

Chief, Professions and Intellectual Property Section, Health Care Task Force, Dept. of Justice, Antitrust Division, 600 E St., NW., Room 9300, Washington, DC 20530.

To: Gail Kursh,

As an owner of an independent home health agency, I recommend that the Department of Justice should allow the hospital discharge planner give a list of all home health agencies serving the neighborhood of the patients residence area. I would also recommend that the patients be given a brochure of the agencies requested by the patient so they will be able to choose the service of their choice. The hospital based agencies should self refer no more than 50% of the patients discharged from the hospital to its own or related home health agency. The discharge planner should give a list of all agencies serving the area to the doctors at the hospital for their information.

I hope my suggestions will help you and the survival of all the independent home health agencies.

Sincerely,

Tom Varughese,

Administrator.

National Home Infusion Association

205 Daingerfield Road, Alexandria, VA 22314, Phone 703–549–3740, Fax 703–683–3619

December 4, 1995.

Gail Kursh,

Chief, Professions & Intellectual Property Section, Health Care Task Force, Department of Justice, Antitrust Division, 600 E Street NW., Room 9300, Washington, DC 20530.

Dear Ms. Kursh: On behalf of the members of the National Home Infusion Association, I am writing to express our concerns regarding the proposed final judgment for *United States* v. *Health Choice of Northwest Missouri, Inc., et al.,* Case No. 95–6171–CV–SJ–6 in U.S. District Court for the Western District of Missouri.

Specifically, while we believe the proposed final judgment in regard to the referral policy is a well intended attempt to address this issue, we are concerned that instead it will further strengthen the growing anticompetitive environment in which institutions capture referrals for their own outpatient service companies.

Nationwide, two out of every three hospitals now offer some form of home care services and the numbers are continuing to grow at a rapid pace. That means that today, institutional inpatients have a higher potential to be captively referred to an institution's own outpatient service company than ever before.

The department's proposed guidelines appear to base the balance to an institution's self-referral with a physician discharging a patient, out of the same institution who grants that physician privileges to work within that institution, into the care of a competitor of that institution and with the hospital's own filtration of information to the patient as it concerns competitors to its outpatient service company(ies).

Our organization routinely receives calls from both outpatient providers and physicians indicating that hospitals are increasingly pressuring physicians and patients, both directly and indirectly, to utilize the hospital's own outpatient services.

It is our belief that outpatient service providers should be allowed unfiltered access to potential referral patients, and that restrictions should be placed on a hospital's ability to pressure physicians. We believe this will create and foster a competitive environment.

Therefore, NHIA urges you to support the incorporation of the Coalition for Quality Health Care's recommendations into the final judgment, namely:

- to strengthen limitations on the hospital's ability to refer its patients to its own hospital-based components; to require the hospital to use a rotation system which assures equitable referrals to all providers in the area; and
- to require the hospital to permit (on their premises, during normal working hours), representatives of freestanding providers—other than their own hospital-based components—to visit their patients who have been admitted for hospitalization; and
- to expose the patient population to the availability of outside services as well; and
- to make the hospital publicly post its daily referrals to both its hospital-based entities and to other providers in the community.

It is NHIA's position that the proposed final judgment needs to recognize that both patients and physicians are in a vulnerable position within an institution and that measures such as those recommended by the Coalition for Quality Health Care need to be incorporated to foster and ensure a competitive environment.

Sincerely,

Robin J. Richardson,

Executive Director.

Visiting Nurse Associations of America

3801 E. Florida Ave., Suite 900, Denver, CO 80210, (303) 753–0218, Fax 753–0258

December 4, 1995.

Ms. Gail Kursh,

Chief Professions & Intellectual Property Section/Health Care Task Force, Department of Justice, Antitrust Division, 600 E Street, NW., Room 9300, Washington, DC 20530.

Re: *United States* v. *Health Choice of Northwest Missouri, Inc., et al.,* Case No. 95–6171–CV–SJ–6 in the U.S. District Court for the Western District of Missouri.

Dear Ms. Kursh: The Visiting Nurse Associations of America (VNAA) presents the following comments to urge the United States Department of Justice (DOJ) to withdraw its consent to the proposed final judgment regarding *United States* v. *Health Choice of Northwest Missouri, Inc., et al.* in order to modify the judgment to better serve the public interest.

VNAA is a national membership organization, representing 210 Visiting Nurse Associations (VNAs) throughout the United States. VNAs are home- and community-based, nonprofit, Medicare-certified home health and hospice agencies. The VNA mission is to provide the most compassionate and cost-effective care possible to our patients without regard to their ability to pay. VNA's services range from homemaker services to skilled nursing care, including high-tech services such as blood transfusions and chemotherapy. HCFA's 1993 data demonstrate that 26% of all Medicare home health admissions that year were to VNAs. VNAs also carry the majority of Medicaid home care and a significant volume of privately-insured home care. Because VNAs have provided care regardless of patients' ability to pay for over 100 years, they have been, and continue to be, the safety net for uninsured and underinsured patients. Charity support allows VNAs to be that safety net, bridging the gap between cost of care and reimbursement.

As the delivery of health care moves increasingly away from the hospital to the home, patients must be assured they have access to a broad range of providers, including free-standing agencies such as VNAs. VNAs have both the historic mission and the cutting edge clinical advances for treating patients in the home. VNAA believes that the policy regarding patient referral by a hospital system to home care and other ancillary services, which is outlined in the proposed final judgment for *United States* v. *Health Choice of Northwest Missouri, Inc., et al.,* would be detrimental to this goal. This judgment, as currently written, would restrict a patient's freedom to choose his or her own home care provider because a patient most likely would not be made aware of all qualified providers in the community at the time of hospital discharge. As a result, the judgment would conflict with current Medicare and Medicaid policy that protects

patient choice and fair competition (42 USC § 1395a) and (42 USC § 1396a(23)).

VNAA requests the DOJ to revise its judgment to better protect patient choice and competition by requiring hospitals to present a written list of local Medicare- and Medicaid-certified home care and other ancillary providers to a patient at the same time that a hospital informs the patient of its own accredited ancillary services. VNAA also requests that participating hospitals be required to provide such patients with a written explanation of the Medicare and Medicaid statutes that protect a patient's freedom-to-choose his or her provider of services and the quality standards the listed certified agencies must meet as specified by the programs' conditions of participation.

Thank you for your consideration of our comments.

Sincerely,

William G. Vanell,

President and CEO.

Home Care Association of America

9570 Regency Square Blvd., Jacksonville, FL 32225, 1–800–386–HCAA

December 1, 1995

Gail Hursh,

Chief Professions & Intellectual Property Section Health Care Task Force, Department of Justice, Antitrust Division, 600 E. Street, N.W., Room 9300, Washington, D.C. 20530.

Re: United States v. Health Choice of Northwest Missouri, et al Case No. 95–6171–CV–SJ–6.

Dear Gail Hursh: I am general counsel for Home Care Association of America (HCAA) which represents two hundred forty (240) home care agencies throughout the United States with nine (9) in Missouri.

We are very cognizant of hospitals similar to Heartland Hospital committing similar offenses and believe that the free standing home health agencies will not be adequately protected by the ''DOJ's Recommended Home Health, DME, and Hospice Referral Policy for Heartland Hospital''.

Under the proposed recommendation, the Hospital will still have an unfair advantage over any home care agency not affiliated with the hospital. The hospital essentially has a captive audience and has no requirement to even suggest that there are other home care agencies in the community that provide similar services. Under II (B)(2) of the recommendation, if a patient has not made a preference, the hospital is in the position to move the patient directly into their own service and the patient would never know the availability of any other service. Patients coming out of a hospital are generally willing to do what ever the hospital staff suggest.

To put a requirement on the patient to make a request for other providers is putting an undue burden on the patient and the other providers in the community. Medicare does not allow advertisement as a reimburseable cost to providers and therefore because the hospital has a captive patient, they are able to inform the patient about their service without any additional cost. Other providers are generally precluded from discussing their services with a patient in the hospital. This gives the hospital a marked advantage because the patient has no choice.

We at HCAA would request that you reconsider your recommendations and modify them as follows:

The hospital shall not be allowed to self refer any more than thirty (30) percent of all the patients which do not have a preference. Patients not having a preference of a specific provider would be referred to providers registered with the hospital on a rotation basis. Thus no agency could be given preferential treatment and the hospital would not monopolize the care for patients who have not been informed as to the services available in the community. Any willing provider qualified under Medicare shall be allowed placement on the referral list and shall receive patients on the rotation basis.

We believe that the above referral plan would be beneficial to all and would not preclude the hospital from self referral completely. This also does not disrupt the hospital by requiring that the other providers be allowed to discuss their services with patients prior to the patient leaving the hospital.

We believe that if you make the above change to your recommendation it will preclude a substantial amount of future litigation in the anti-trust area with hospitals.

We request that you reconsider your recommendations and include our suggested change.

If you should have any questions, or would like to discuss this further, please feel free to contact me directly.

Sincerely,

H. Kenneth Johnston II,

General Counsel.

cc: Dwight Cenac, Chairman of the Board

NARD Legislative Defense Fund, National Association of Retail Druggists

205 Daingerfield Road, Alexandria, Virginia 22314

December 1, 1995.

Gail Kursh,

Chief, Professions & Intellectual Property Section, Health Care Task Force, Department of Justice, Antitrust Division, 600 E Street, NW, Room 9300, Washington, D.C. 20530.

Dear Ms. Kursh: The purpose of this correspondence is to express our concerns regarding the proposed final judgment for *United States* v. *Health Choice of Northwest Missouri, Inc., et al.,* Case No. 95–6171–CV–SJ–6 in U.S. District Court for the Western District of Missouri.

On behalf of our members in Missouri and throughout the country, we urge you to support the incorporation in the final judgment and recommendations of the Coalition for Quality Health Care, namely:

- to strengthen limitations on the hospital's ability to refer its patients to its own hospital-based components; to require the hospital to use a rotation system which assures equitable referrals to all providers in the area; and
- to require the hospital to permit (on their premises, during normal working hours,) representatives of freestanding providers—other than their own hospital-based components—to visit their patients who have been admitted for hospitalization; and
- to expose the patient population to the availability of outside services as well; and
- to make the hospital publicly post its daily referrals to both its hospital-based entities and to other providers in the community.

On behalf of more than 75,000 independent retail pharmacists nationwide, we reiterate our concern that the final judgment be formulated to assure that consumers truly have a choice of competitors.

The ability of the consumer to select the health care provider or health care entity of their choice is an essential ingredient in maintaining a competitive environment in our marketplace.

Sincerely,

John M. Rector,

Senior Vice President of Government Affairs and General Counsel.

In The United States District Court, For The Western District of Missouri

United States of America, Plaintiff, v. *Health Choice of Northwest Missouri, Inc., Heartland Health System, Inc., and St. Joseph Physicians, Inc.,* Defendants. Civil Action No. 95–6171–CV–SJ–6.

Motion For Leave To Appear As Amicus Curiae, File Briefs and Participate In Hearings On Proposed Final Judgment

The Coalition for Quality Healthcare, a nonprofit Missouri corporation organized to assure consumer access to timely and relevant information and to promote competitiveness in the health care field, hereby moves the Court, pursuant to 15 U.S.C. § 16(b), for leave to appear as Amicus Curiae in this case and to file the accompanying Memorandum of Amicus Curiae in Opposition to Proposed Final Judgment in this matter. Amicus also respectfully requests that it be allowed to present evidence and participate in oral arguments in support of its Memorandum of Amicus Curiae in any proceedings held by the Court to determine whether approval of the proposed Final Judgment is in the public's interest.

In support of its Motion, Amicus attaches and incorporates its Memorandum of Law.

Respectfully submitted,

Armstrong, Teasdale, Schlafly & Davis.

Thomas M. Bradshaw, Mo. 20411,

Dianne M. Hansen, Mo. 40356,

1700 City Center Square, 1100 Main Street, Kansas City, Missouri 64105, (816) 221–3420, (816) 221–0786 FAX.

and

Glenn E. Davis, Mo. 30308,

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One Metropolitan Square, Suite 2600, St. Louis, Missouri 63102–2704, (314) 621–5070.

Attorneys for Amicus Curiae, The Coalition for Quality Healthcare

Certificate of Mailing

I hereby certify that a true and correct copy of the foregoing document was mailed, postage prepaid, this 1st day of December, 1995, to the following counsel of record:

Lawrence R. Fullerton, Esq., Edward D. Eliasberg, Jr., Esq., Antitrust Division, U.S. Dept. of Justice, 600 E Street, N.W., Room 9420, BICN Bldg., Washington, D.C. 20530

Thomas D. Watkins, Esq., Watkins, Boulware, Lucas, Miner, Murphy & Taylor, 3101 Frederick Avenue, St. Joseph, MO 64506–0217

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Brian B. Myers, Lathrop & Norquist, 2345 Grand Avenue, Suite 2600, Kansas City, MO 64108

Dianne M. Hansen,

Attorneys for Amicus Curiae, The Coalition for Quality Healthcare.

In The United States District Court, For The Western District of Missouri

United States of America, Plaintiff, v. *Health Choice of Northwest Missouri, Inc., Heartland Health System, Inc., and St. Joseph Physicians, Inc.,* Defendants. Civil Action No. 95–6171–CV–SJ–6.

Memorandum of Law In Support of Motion To Appear As Amicus Curiae and To File Amicus Brief and To Participate In Proceedings On Proposed Final Judgment

For the reasons set forth below, the Coalition for Quality Healthcare, requests permission to appear as Amicus Curiae and to file, and to have the Court consider, the accompanying Memorandum of Law of Amicus Curiae in Opposition to the Proposed Final Judgment in *United States* v. *Health Choice of Northwest Missouri, Inc., et al.,* No. 95–6171–CV–SJ–6.

Amicus also requests the opportunity to be heard and present evidence at any hearing scheduled by the Court to determine whether approval of the proposed Final Judgment is in the public's interest.

Status of Amicus Curiae

The Coalition for Quality Healthcare (the ''Coalition'') is a nonprofit Missouri corporation organized to assure consumer access to timely and relevant information and to promote competitiveness in the healthcare field. The Coalition is comprised of concerned citizens and providers of ancillary healthcare services in Northwest Missouri, including St. Joseph, Missouri and its surrounding areas. Members of the Coalition include owners of long-term care facilities, home health care agencies, pharmacies, medical equipment companies, and other service oriented businesses operating in the healthcare field.

The Coalition believes that the proposed Final Judgment is not in the public's interest. The terms and provisions of the ''referral policy'' which is incorporated into the Final Judgment, if approved by this Court, will directly injure members of the public, including patients who will be denied the right to make an informed choice among all available ancillary services providers, and non-Heartland ancillary services providers who will be foreclosed from obtaining business from patients being discharged from Heartland's acute care hospital. The practical effect of the referral policy is that Heartland will continue to increase its monopoly power in the ancillary services market through predatory practices and leveraging, causing antitrust injuries.

On November 22, 1995, pursuant to the Tunney Act, the Coalition filed its formal Comment with this Court, directed to the Department of Justice, Antitrust Division. Amicus now seeks the Court's permission to supplement its Comment with the attached Memorandum of Amicus Curiae setting forth arguments and authorities in opposition to the proposed Final Judgment and recommending to the Court alternative provisions, including a model referral policy, which the Coalition believes will better serve the public's interest.

Amicus further seeks permission to participate in any proceedings or hearings before this Court to determine whether the proposed Final Judgment is in the public's interest.

Statutory Right to Appear as Amicus Curiae

Under Section 16(f) of the Tunney Act, 15 U.S.C. § 16, the Court may authorize full or limited participation in proceedings before the court by interested persons or agencies, including appearance amicus curiae, intervention as a party pursuant to Fed.R.Civ.P. 24, examination of witnesses or documentary materials, or participation in any other manner and extent which serves the public interest as the Court may deem appropriate. *Id* §§ 16(f)(3), 16(f)(5).

Courts frequently permit amicus submissions in Tunney Act proceedings. *See e.g. United States* v. *Microsoft Corp.,* 56 F.3d 1448 (D.C. Cir. 1995); *United States* v. *Airline Tariff Publishing Co.,* 1993–1 Trade Cases ¶ 70,191 (D.C. Dist. 1993); *United States* v. *International Telephone & Telegraph Co.,* 349 F.Supp. 22, 26 n.2 (D. Conn. 1972).

The Coalition believes that the proposed consent decree is of the greatest possible importance to the citizens and patients utilizing acute healthcare services and ancillary healthcare services in Northwest Missouri and Northeast Kansas. As discussed more fully in the accompanying Memorandum of Amicus Curiae, the Final Judgment and Competitive Impact Statement filed by the Department of Justice fails to provide the Court with either the factual or economic analysis necessary for the Court to determine whether the proposed decree is sufficient to restore competition to the managed care services and ancillary healthcare services markets within Heartland's geographic region. Nor has Heartland supplied the affidavits of even a single economist describing the likely consequences of the proposed referral policy on the existing ancillary services market. *Compare e.g., United States* v. *Western Electric Co., Inc.,* 993 F.2d 1572, 1578–1582 (D.C. Cir. 1993) (describing numerous affidavits from economic experts that provided factual record for determining whether proposed decree and modification was in the public interest).

The Court must look at the competitive impact of a proposed judgment upon the public generally and upon individuals or entities alleging specific injury from the violations set forth in the compliant. *See* 15 U.S.C. § 16(3). In the Memorandum of Amicus Curiae, the Coalition describes in detail, supported with letters from its members, the anticompetitive effect that the proposed consent decree will have on both ancillary service providers and non-Heartland physicians, and economic data indicating that members of the public have suffered and will continue to suffer antitrust injuries if the proposed Final Judgment and the incorporated referral policy are approved.

In view of the paucity of the existing record, consideration of additional submissions under Section 16(f) is particularly appropriate.

Conclusion

For the foregoing reasons, amicus respectfully requests that the Court grant it leave to file the accompanying Memorandum under section 16(f) of the Tunney Act, 15 U.S.C. § 16, and that the Court further consider the Memorandum on the merits in making its public interest determination under Section 16(e). Finally, amicus respectfully requests that the Court allow it to present evidence and participate in any proceedings before this Court to determine whether the proposed Final Judgment is in the public's interest.

Respectfully submitted,

Armstrong, Teasdale, Schlafly & Davis

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Attorneys for Amicus Curiae, The Coalition for Quality Healthcare

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Dianne M. Hansen,

Attorneys for Amicus Curiae, The Coalition for Quality Healthcare.

In the United States District Court, for the Western District of Missouri

United States of America, Plaintiff, v. *Health Choice of Northwest Missouri, Inc., Heartland Health System, Inc., and St. Joseph Physicians, Inc.,* Defendants. Civil Action No. 95–6171–CV–SJ–6.

Order

On Motion for Leave to Appear as Amicus Curiae in the above matter brought by the Coalition for Quality Healthcare, and for good cause shown,

IT IS HEREBY ORDERED that the Coalition for Quality Healthcare is hereby granted leave to appear as Amicus Curiae in this case, including the right to file briefs, participate in oral arguments and present evidence at any hearings scheduled by the Court to determine whether approval of the proposed Final Judgment is in the public's interest.

IT IS SO ORDERED.

HON. HOWARD F. SACHS,

Sr. U.S. District Judge.

In the United States District Court, for the Western District of Missouri

United States of America, Plaintiff, v. *Health Choice of Northwest Missouri, Inc., Heartland Health System Inc., and St. Joseph Physicians, Inc.,* Defendants. Civil Action No. 95–6171–CV–SJ–6.

Memorandum of Amicus Curiae in Opposition To Proposed Final Judgment

Armstrong, Teasdale, Schlafly & Davis

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The Coalition for Quality Healthcare (the ''Coalition''), as amicus curiae, submit for the Court's consideration and information the following arguments and authorities in opposition to the proposed Final Judgment in this matter.

I. Background

The Antitrust Division of the Department of Justice (''DOJ'') has determined that between April 14, 1986 and June 9, 1995, Health Choice of Northwest Missouri, Inc. (''Health Choice''), Heartland Health System, Inc. (''Heartland''), St. Joseph Physicians, Inc. (''SJPI'') and others acted in concert to restrain or prevent the development of competitive managed health care programs in Buchanan County, Missouri, Complaint, ¶ 25. The DOJ found that this anticompetitive conduct constitutes an unreasonable restraint of price and other competition among managed care plans and among physicians in Buchanan County, which deprives consumers and third-party payers of the benefits of free and open competition in the purchase of health care services in Buchanan County. Complaint, ¶ 27.

The Coalition is a nonprofit Missouri corporation organized to assure consumer access to information and to promote competition in the healthcare field. It is comprised of concerned citizens and providers of ancillary healthcare services in Northwest Missouri, including St. Joseph, Missouri and its surrounding areas. Members of the Coalition include owners of long-term care facilities, home health care agencies, pharmacies, medical equipment companies, and other service oriented businesses operating in the healthcare field. The Coalition believes that the deleterious effects of defendants' anticompetitive conduct reaches beyond those enumerated in the Complaint and impacts not only the consuming public and physicians, but also all ancillary services providers operating within Heartland's geographic region who are not affiliated with Heartland.

The Coalition understands that the principal focus of the DOJ's investigation resulting in the proposed consent judgment related to defendants' efforts to interfere with managed care programs, and that the subject of ancillary services arose very late in the investigation process. It is noteworthy that the Complaint before the Court makes no reference to ancillary services at all. The DOJ has informed the Coalition that it has no ''determinative materials'' from the investigation concerning the ''referral policy'' referred to in the Final Judgment. In sum, as the proposed judgment relates to ancillary services, the Coalition believes that the referral policy itself is beyond the scope of the Complaint, is an ill-advised addition to the proposed consent judgment, and is included in the proposed judgment without adequate investigation and attention to its consequences. Accordingly, the Coalition's objections to the proposed Final Judgment, and in particular the referral policy it includes, are both procedural and substantive in nature.

As discussed in this Memorandum, the proposed Final Judgment, which incorporates Heartland's ancillary services ''referral policy'' [1] into its terms, is *not* in the public's interest because it violates a consumer/patient's right to make an informed choice among all ancillary services providers and because the referral policy enhances Heartland's capacity to monopolize the

[1] Attached as Exhibit 1 is a copy of the Heartland Ancillary Services Referral Policy which is incorporated into the terms of the proposed Final Judgment.

ancillary services market within Northwest Missouri and Northeast Kansas. Further, the proposed Final Judgment lacks an effective, affirmative Compliance Program since it relies solely on ''self-reporting'' by the defendants. Finally, the Final Judgment contains no provisions detailing the manner in which alleged violations of the consent decree should be brought before the Court for appropriate judicial enforcement proceedings.

For these reasons, as set forth in the Comment previously filed by Amicus on November 22, 1995,[2] and as set forth more fully below, amicus curiae opposes the proposed Final Judgment.

II. The Permissible Scope of This Court's Review

In 1974, Congress enacted the Antitrust Procedures and Penalties Act (''APPA''), also known as the Tunney Act, 15 U.S.C. §§ 16 (b)–(h) (1995), out of concern with ''prior practice, which gave the [Justice] Department almost total control of the consent decree process, with only minimal judicial oversight.'' *United States* v. *American Tel. & Tel.,* 552 F.Supp. 131, 148 (D.D.Cir. 1982), *aff'd sub nom., Maryland* v. *United States,* 460 U.S. 1001 (1983). Congress sought to eliminate ''judicial rubber stamping'' of such consent decrees[3] by providing that ''before entering any consent judgment * * * the court shall determine that the entry of such judgment is in the public interest.'' 15 U.S.C. § 16(e).

The legislative history of the Tunney Act shows that Congress did not intend the court's action to be merely pro forma. *United States* v. *Gillette Co.,* 406 F.Supp. 713, 715 (D. Mass. 1975). When the government and putative defendant(s) present a proposed consent decree to the district court for review under the Tunney Act, the court can and should inquire into the purpose, meaning and efficacy of the proposed decree. *U.S.* v. *Microsoft Corp.,* 56 F.3d 1448, 1462 (D.C.C. 1995). Moreover, if third parties contend that they have been positively injured by the decree, a district judge should hesitate before assuming that the decree is appropriate. *Id.* Similarly, a district court is expected to closely scrutinize the compliance mechanisms of a proposed consent decree. *Id.*

In making its inquiry, many courts have held hearings,[4] with testimony of experts, witnesses, and interested persons,[5] and ordered the DOJ to produce its ''determinative'' documents and materials to interested parties, as required by Section 16(b) of the Tunney Act.[6] For example, in *United States* v. *Central Contracting Co., Inc.,* 537 F.Supp. 571 (1982), the DOJ asserted that ''there were simply no documents or materials * * * that contributed materially to the formulation of the proposed relief.'' *Id.* at 573. The district court found the government's assertion disingenuous in light of the government's similar claims in 172 out of 188 prior cases that it considered neither documents nor any materials determinative. *Id.* at 577. The Court refused to blandly (and blindly) accept the government's certification that no documents or materials led to the government's determination that it should enter into a consent decree. *Id.* at 575. Rather, the Tunney Act required a ''good faith review of all pertinent documents and materials and a disclosure'' of those materials called for by the Act. *Id.* at 577.

A pro forma approval is certainly not warranted here. The well-publicized and lengthy investigation into the defendants' activities has resulted in a proposed final judgment that reaches beyond the DOJ's managed care investigation and includes a wholly deficient referral policy relative to ancillary services. Amicus curiae formally requested copies of any ''determinative'' materials or documents from the DOJ so that its counsel could properly evaluate the terms and conditions of the proposed Final Judgment and Competitive Impact Statement.[7] The Department of Justice denied that any such documents exist.[8] Accordingly, the Court should carefully evaluate whether this is in the public interest, particularly when the DOJ has not been forthcoming with disclosure of the underlying factual materials supporting the proposed policy.

Amicus respectfully requests the Court to hold a hearing to determine whether the proposed consent decree is in the public's interest and to allow amicus to present evidence, including testimony, to support its arguments, as outlined below, that the consent decree is not in the public's interest.

III. Arguments and Authorities

A. The Final Judgment is not in the public's interest because the incorporated Heartland Referral Policy prevents patients from making an informed choice regarding ancillary services.

Heartland has diversified into the ancillary services market and now owns, operates or otherwise controls or is affiliated with various ancillary services providers including a skilled nursing facility, a rehabilitation facility, a pharmacy, and a home health care agency. Heartland now competes with other ''downstream providers'' in the ancillary services market and, through its referral policy and discharge practices, unfairly monopolizes that market by ''steering'' or ''channeling'' its patients to its affiliated ancillary services providers. The channeling of patient choice is sufficient to show injury to consumers and a violation of the antitrust laws. *Key Enterprises of Delaware, Inc.,* 919 F.2d 1550, 1559 (11th Cir. 1990), vacated with instructions to dismiss (due to post-appeal settlement of case), 9 F.3d 893 (11th Cir. 1993).

Anticompetitive steering tactics include, but are not necessarily limited to, referring all business to the hospital-affiliated service providers when the patient is offered no meaningful choice among competing suppliers;[9] refusing

[2] A copy of the Comment filed by the Coalition for Quality Healthcare with the Department of Justice is attached as Exhibit 2.

[3] As a sponsor of the Act, Senator Tunney declared: ''Specifically, our legislation will * * * make our courts an independent force rather than a rubber stamp in reviewing consent decrees, and it will assure that the courtroom rather than the backroom becomes the final arbiter in antitrust enforcement.'' *The Antitrust Procedures and Penalties Act: Hearings on S. 782 and S. 1088 before the Subcommittee on Antitrust and Monopoly of the Committee on the Judiciary,* 93d Cong., 1st Sess. (1973).

[4] *See, e.g., United States* v. *Westinghouse Elec. Corp.,* 1988 WL 47345 (D.D.C.); *United States* v. *Bechtel Corp.,* 1979 WL 158 (N.D. Cal.), *aff'd* 648 F.2d 660 (9th Cir. 1981), *cert. denied,* 454 U.S. 1083; *United States* v. *Mid-America Dairymen, Inc.,* 1977 WL 4352(W.D. Mo.).

[5] To facilitate its review, the district court may ''authorize full or limited participation in proceedings before the court by interested persons or agencies.'' 15 U.S.C. § 16(f)(3). *United States* v. *BNS, Inc.,* 858 F.2d 456, 459 (9th Cir. 1988).

[6] The court can also condition approval of a consent decree on the Antitrust Division's making available information and evidence obtained by the government to potential, private plaintiffs which will assist in the effective prosecution of their claims. *United States* v. *Associated Milk Producers, Inc.,* 394 F.Supp. 29, 45 (W.D. Mo. 1975), *citing* U.S. Code Cong. and Admin. News 1974, 93rd Cong. 2nd Sess., pp. 6538–39.

[7] By letter of November 13, 1995, the Coalition requested the Department of Justice to produce a list of determinative materials to its counsel. (*See* Exhibit 3, attached.)

[8] On November 21, 1995, the Department of Justice, Antitrust Division, responded to the Coalition that the Department had determined that no such materials or documents existed. (*See* Exhibit 4, attached.)

[9] Frequently, patients will have no immediate preference among downstream suppliers because they remain too ill to make a rational choice, because they lack information about the competitive attributes of different suppliers, because the information they do have provides little objective guidance about the services provided by different companies, or because the cost of the products and services will be paid by third party payors and thus little incentive exists to engage in price comparisons. Or the patient simply may place

Continued

to make available materials concerning the services of competing suppliers; and permitting hospital-affiliated service providers access to patients needing ancillary services but denying access to competitors. *See* J. Miles, *Health Care & Antitrust Law,* ''Provider Diversification,'' ch. 14 § 14.01 (Clark, Boardman & Callaghan 1995).

The antitrust laws do not require the consumer to suffer some form of direct or immediate monetary damage before a defendant's anticompetitive conduct is actionable. Being denied equal access to services is sufficient to violate the antitrust laws. *See Aspen Skiing Company* v. *Aspen Highlands Skiing Corp.,* 472 U.S. 585, 105 S.Ct. 2847, 2859–60 (1985) (consumers injured by not having easy access to all four skiing mountains); *see also Association of General Contractors of Cal.* v. *California St. Council of Carpenters,* 459 U.S. 519, 103 S.Ct 897, 903 (1983) (''coercive activity that prevents its victims from making free choices between market alternatives is inherently destructive of competitive conditions and may be condemned even without proof of its actual market effect.'').

In *Key Enterprises,* a hospital, after forming a durable medical equipment company (''DME'') joint venture, steered its patients needing DME to the venture. The hospital changed two longstanding policies after the venture was formed. First, although no DME vendors had been permitted access to hospital patients prior to the venture, only representatives of the venture were permitted access to patients needing DME afterward. Second, although independent home health nurses had been primarily responsible for selecting the appropriate DME vendor prior to the venture, a representative of the venture subsequently took that responsibility.

In addition, the hospital instituted a default policy by which patients without a preference of a DME supplier would be referred to the venture automatically whereas a rotation system among DME vendors had been used previously. *Id.* at 1558. As a result of these practices, the DME venture's market share promptly increased from about 9 percent prior to the venture with the hospital to around 61 percent, while the competing DME's market share decreased from about 73 percent to 30 percent. Moreover, 64 percent of the venture's business consisted of the hospital's patients and about 85 percent of all hospital referrals for DME went to the venture. *Id.* at 1566. In upholding a jury verdict on the attempted monopolization claim, the appeals court held that the hospital's conduct was predatory and sufficient to show a dangerous probability of monopolization. *Id.*[10]

The proposed Final Judgment in this case entrenches the defendants' ability to engage in anticompetitive practices and to violate the antitrust laws because it requires Heartland physicians to ''observe the attached and incorporated Heartland referral policy relating to the provision of ancillary services.'' Final Judgment, VII (B)(1). That referral policy impermissibly steers or channels Heartland patients to Heartland-affiliated ancillary services providers:

(1) The policy allows the doctor to initially order that a particular ancillary services provider be used, rather than allow the patient to choose freely among any of the ancillary services providers in the Northwest Missouri area. Because Heartland employs or is otherwise associated with the majority of physicians with staff privileges at Heartland's hospital, doctors will routinely order Heartland ancillary services providers for the patient. Hospital patients requiring ancillary services are frequently elderly, in ill health and are unlikely to question, let alone contest, a doctor's order, or to understand the basis for the recommendation or any underlying conflict of interest.

(2) Even if the doctor does not designate a certain ancillary services provider, the patient is nonetheless ''steered'' to Heartland because the patient is only informed that Heartland has excellent, fully accredited ancillary services available and then the patient is given a Heartland brochure. The patient is *not* informed about the availability of any competing ancillary services providers in the Northwest Missouri area.

(3) If the patient rejects Heartland's ancillary services providers, or specifically asks what other providers are available, the patient is *not* given the names of or any information about non-Heartland providers. Rather, the patient is told that Heartland cannot provide any information about or recommend any of the other ancillary services providers and the patient is then merely referred to the telephone book to look for other providers.

If a firm attempts to exclude rivals on some basis other than efficiency, it is fair to characterize its behavior as ''predatory.'' *Aspen Skiing Company* v. *Aspen Highlands Skiing Corp.,* 472 U.S. 585, 605 (1985). The predatory effect of Heartland's mandated referral policy is that consumers are channeled to Heartland-affiliated ancillary services providers, rather than being given timely and equal access to sufficient information on all ancillary services options and quality to be allowed to make an informed choice among those options. The presence of the referral policy in the proposed Final Judgment is a thinly-disguised but calculated effort to obtain the imprimatur of the Court's approval on a referral policy designed to maintain entry barriers to other ancillary service providers and enhance the defendants' market power.

B. Heartland, through its Referral Policy, effectively monopolizes the ancillary services market within Heartland's geographic service region, resulting in antitrust injury to consumers and other ancillary services providers.

The proposed Final Judgment and its incorporated referral policy impair competition in an unnecessarily restrictive way by foreclosing competing ancillary services providers from obtaining access to patients being discharged from acute care. The effect on competing ancillary service providers is devastating, because patients being discharged from acute care are a critical source of business for competing ancillary services providers. The effect of the referral policy is especially onerous because Heartland is the only acute care facility located in Buchanan County, Missouri. The closest comparable facility is North Kansas City Hospital, located in Clay County, Missouri, 60 miles south of St. Joseph.

To the extent that Heartland patients are systematically and successfully ''steered'' to Heartland affiliated service providers, competitors will be foreclosed from that source of patients. This raises serious antitrust concerns because there may be an insufficient number of remaining referrals for competitors to remain viable. The hospital-affiliated ancillary services providers are already obtaining a substantial market share and an unwarranted degree of market power in the ancillary services market, enabling them to raise and sustain prices above (or lower quality below) levels that would be achieved in a truly competitive marketplace.

Although firms have no duty under the antitrust law to promote their competitors, there are recognized exceptions to this rule in hospital diversification cases. One exception,

substantial trust in the hospital or its doctor and thus select its affiliated company because of its affiliation with the hospital. J. Miles, *Health Care & Antitrust Law,* ''Provider Diversification,'' ch. 14, § 14.01 (Clark, Boardman & Callaghan 1995).

[10] Attached as Exhibit 5 for the Court's convenience is a copy of the *Key Enterprises* opinion which contains a thorough discussion of anticompetitive practices such as ''channeling'' and ''leveraging'' in a hospital diversification case.

applicable to the Heartland case, is where a hospital ''leverages'' its market power in one market (the ''upstream'' acute care market) to obtain a competitive advantage in a second separate market (the ''downstream'' ancillary services market). *See e.g., Advanced Health-Care Services, Inc.* v. *Radford Community Hospital,* 910 F.2d 139 (4th Cir. 1990) (hospital with monopoly power in the market for acute care hospital services can use that power to foreclose competition and gain unfair competitive advantage in the downstream market for ancillary services and DME); *Key Enterprises,* 919 F.2d at 1566–68.

The terms and the practical effect of Heartland's referral policy allow Heartland to gain an unfair competitive advantage in the ancillary services market. Comments and data supplied by competitors of Heartland-affiliated ancillary services underscore the concerns about the anticompetitive aspects of the proposed consent decree.[11] Specific examples of these concerns follow.

Patients from private (non-Heartland) long-term care facilities who are transferred to Heartland's hospital for acute care are not returned to the private long-term care facility upon discharge, even if the patient had been a long term resident of the private facility. Rather, the patients are transferred to either Heartland's skilled nursing facility, which charges a higher daily rate than comparable facilities in the community, or to Heartland's rehabilitation center. The patients are then kept in these Heartland care facilities until their Medicare coverage is exhausted. The patients are only returned to their former private facility if Heartland does not want them or if there is no Medicare coverage or private source of payment for the patient's care.

Patients of private home health care agencies experience similar exclusion from their prior provider. Patients who have been cared for by a non-Heartland home health care agency prior to being admitted to Heartland's hospital are not returned to that agency upon discharge. Instead, patients are being directed to Heartland's home health care unless the patient objects to the doctor's order or recommendation to use Heartland. The patients in question are often elderly, infirm and vulnerable, and may be unaware that they can object to a change in home health care providers and insist that their former agency resume care upon the patient's discharge, or unable to assert their right to do so.

Heartland hospital staff do not give notice to a patient's prior ancillary services provider when that patient is to be discharged from the hospital. In some instances, prior providers report that their patients have been home for two to four days with no follow-up care by their home health care agency because the hospital failed to notify the former provider of the patient's discharge. This is grossly harmful to the patient and greatly affects the quality of the patient's care.

C. The Final Judgment contributes to cause direct antitrust injury to the public.

Owners of private long-term care facilities and home health care agencies uniformly report a significant loss in revenue, patient census and hospital referrals since Heartland began its referral policy.[12] Figures obtained from the 1994 Home Health Agency Annual Report show that among four competing home health care agencies operating in the St. Joseph, Missouri region, Heartland Home Care admitted almost 300 more new patients to its home health care service than its next closest competitor in St. Joseph, Missouri.[13]

An institutional pharmacy which serves 60 private (non-Heartland) nursing homes in St. Joseph and the surrounding area has lost significant amounts of business due to the overall loss of private nursing home patients to the Heartland system.[14] Heartland's own pharmacy services the needs of patients using Heartland's ancillary services.

The Coalition believes these developments are not the result of Heartland's provision of superior or more efficient care or services. Rather, these trends reflect the effects of the referral policy, discharge practices, and other conduct by Heartland to steer patients to its own services and those of its affiliates.

D. Heartland's Referral Policy is inconsistent with federal regulations related to Discharge Planning that govern Medicare and Medicaid hospitals and with standards of the Joint Commission for Accreditation of Healthcare Organizations (''accreditation standards'') to which Heartland subscribes.

Heartland's referral policy does not allow ancillary services providers, who have an established relationship with the patient before admission to Heartland's acute care hospital, to participate in discharge planning for their patients, thus preventing the providers from competing in the marketplace for the patient's business. Providers are given no notice of their patient's discharge by Heartland and have been specifically denied the opportunity to participate in discharge planning meetings for their patients. Heartland's referral policy is inconsistent with new federal regulations pertaining to discharge planning for the patient and with accreditation standards pertaining to informed consent by patients.

Effective January 12, 1995, the Health Care Financing Administration (HCFA) issued new regulations adopting more specific patient discharge planning standards for hospitals participating in Medicare and Medicaid programs. 42 CFR § 482.43.[15] The new regulations require, among other things, that a Medicare/Medicaid participating hospital:

(1) Identify at an early stage of hospitalization those patients likely to suffer adverse health consequences without discharge planning. § 482.43(a).

(2) Provide a ''discharge planning evaluation'' to such patients and to others upon request, which must include an evaluation of:

(a) The likelihood of a patient needing post-hospital services and of the availability of the services. § 482.43(b)(3).

(b) The likelihood of a patient's capacity for self-care or of the patient being cared for in the environment from

[11] Attached as Exhibit 6 are letters from various ancillary services providers who compete with Heartland in the Joseph, Missouri service provider area, objecting to the proposed Final Judgment and explaining the direct impact of the Referral Policy on those providers.

[12] See Exhibit 6. Carriage Square Health Care Center reports that medicare patient days decreased from 5,689 in 1989 to 91 in 1995; St. Joseph Convalescent Center reports a loss of 1,302 patient days in 1993–94, 1,369 patient days in 1994–95, and 1,091 patient days between July, 1995 and September, 1995; Tiffany Square Convalescent Center reports that its occupancy rate dropped from 93.5% in 1993 to 79.7% in 1995; and Caregivers Home Health, Inc. reports that hospital patient referrals for home health care dropped from a high of 22 patients per month to a low of 8 patients per month during the period January, 1994 to July, 1995.

[13] See Exhibit 7, 1994 Home Health Agency Annual Reports for Heartland Home Care, Caregivers Home Health, Inc., Benders Home Care, Inc. and Kendallwood Home Health. [Note that the patient census figures for Kendallwood have been reduced by 50% on the Recap Sheet #1 to reflect only Kendallwood's St. Joseph agency, since Kendallwood operates another agency outside of the St. Joseph, Missouri region].

[14] See Exhibit 6, letters from Lipira Pharmacy indicating a yearly loss in revenue of between $80,000 to $100,000 due to loss of patients to Heartland's skilled nursing facility or Heartland's rehabilitation facility.

[15] Attached as Exhibit 8 is a copy of the Final Rule, published in 59 Fed. Reg. 64141 (December 13, 1994).

which he or she entered the hospital. § 482.43(b)(4).

(3) Discuss the results of the evaluation with the patient or individual acting on his or her behalf. § 482.43(b)(6).

(4) If the evaluation indicates the need for a discharge plan, an RN, social worker, or other appropriately qualified personnel must develop such a plan. § 482.43(c)(1);

(5) As needed, the patient and family members or interested persons must be counseled to prepare them for post-hospital care. § 482.43(c)(5).

The hospital has an obligation under these new regulations to evaluate the patient's capacity to return to the pre-hospitalization environment, which necessarily includes the ancillary services providers involved with the patient's care before the hospitalization. If the patient elects to return to the care of the same ancillary service provider as before hospitalization, it is reasonable to consider that pre-hospitalization ancillary services provider to be an ''interested person'' who must be ''counseled'', i.e. advised of the planned discharge date for the patient, in order to assure that appropriate arrangements are made on a timely basis.

One of the comments discussed by the HCFA in the Order of Rulemaking suggests that the hospital be required to give each patient the full range of options to consider for post-hospital care. In responding, HCFA stated that: ''In most instances the focus on a return to the prehospitalization environment is a valid one, serving the interests of the patient within available community resources.'' HCFA concluded that the new regulation did not preclude a patient from being offered a full range of options to consider for post-hospital care and determined that no further change to the regulation was necessary. 64 Fed. Reg. 64147. The HCFA also agreed to incorporate, into the HCFA's ''Interpretive Guidelines'' covering discharge planning, the requirement that the hospital should ''maintain complete and accurate information on community long-term care services and facilities for advising patients and their representatives of their options.'' 59 Fed. Reg. 64148.[16]

The Joint Commission for Accreditation of Healthcare Organizations (''JCAHO'') has established standards for accredited hospitals governing Patient Rights and Organization Ethics, with the stated goal of helping to ''improve patient outcomes by respecting each patient's rights and conducting business relationships with patients and the public in an ethical manner''.[17] An accredited hospital is required to obtain informed consent for all patient care, including discharge planning services. JCAHO Standard RI.1.2.1. The stated JCAHO intent for this requirement is to ensure that the hospital's staff clearly explain to the patient and, when appropriate, the patient's family, ''any professional relationship to another health care provider or institution that might suggest a conflict of interest.'' JCAHO Standard RI.1.2.1. This standard requires Heartland's physicians or other staff members treating the patient, to explain to the patient any business relationships between the treating physician or hospital and any other organization of health care service involved in the patient's care, including Heartland's affiliation with certain ancillary service providers.

Moreover, an accredited hospital must operate according to a code of ethical behavior. JCAHO Standard RI.4. The JCAHO's stated intent for this standard is that a hospital must conduct its business patient care activities in an honest, decent, and proper manner, which includes marketing, admission, transfer, and discharge functions. JCAHO Standards RI.4

Heartland's referral policy, the manner in which it manages discharge planning functions, and related conduct are inconsistent with both the HCFA regulations and the JCAHO standards.

E. The Court should strike the Referral Policy from the Final Judgment, or in the alternative, order Heartland to adopt a revised policy such as the ''Model Referral Policy'' submitted by Amicus Curiae.

For those reasons set forth in Part III (A) to (D) above, amicus urges the Court to strike Heartland's referral policy from the terms and conditions of the proposed Final Judgment. The referral policy is not a necessary component for the protection of managed care, the principal thrust of the proposed judgment and the entire focus of the Complaint. Even if it does relate to managed care issues, however, it should be rejected as inappropriate. In the alternative, amicus respectfully suggests that the parties adopt or the Court impose a substitute referral policy whose terms and conditions are similar to those set forth in the ''Model Referral Policy'' attached to this Memorandum as Exhibit 9.

Anticompetitive concerns, whether directly related to managed care or not, can best be met through a referral policy that affords each patient equal access to and information about all ancillary services available within Heartland's geographic region. By the same token, the policy should provide ancillary services providers equal access to Heartland patients. Amicus curiae strongly believes that its Model Referral Policy achieves these objectives. The highlights of the policy include the following provisions:

1. The hospital must commit to promote and support a patient's right to make an informed choice by ensuring that its staff and employees implement and follow the terms of the referral policy.

2. The policy is to be administered and monitored by an independent social worker or ''ombudsman,'' whose salary and expenses could be shared equally among the competitors (including Heartland), in order to preserve the ombudsman's independence.

3. When ancillary services are ordered by a physician, the ombudsman must fully inform the patient of all options for ancillary services within Heartland's geographic region and insure that a patient's choice of provider is honored.

4. When a patient is admitted to Heartland's hospital from a private long-term or skilled nursing facility, or if a patient is a current client of a home health care agency, that provider's name should be noted on the patient's chart. Prior ancillary services providers must be notified of and encouraged to participate in any discharge planning for their patients.

5. All ancillary services providers will be allowed access to Heartland patients who request contact with that provider, or if the patient is a current client of that provider. Further, all ancillary services providers should be allowed to supply the ombudsman with brochures about their services which will be available to the patient, but not to competing ancillary services providers.

A referral policy embracing the foregoing provisions would promote healthy competition in the ancillary services market and ''level the playing field.''

F. The terms of the Final Judgment give unfair competitive advantage to Heartland in the primary care physician market.

Other terms and conditions of the Final Judgment give unfair competitive advantage to Heartland in the primary care physician market. Specifically,

[16] As of the date of filing this Memorandum, the HCFA had not yet issued new Interpretive Guidelines incorporating the referenced requirement.

[17] Joint Commission for Accreditation of Healthcare Organizations, ''Patient Rights and Organizational Ethics,'' § 1 (1995).

under the terms of the proposed consent decree, Heartland is allowed to employ or acquire, without preapproval from the DOJ, an unlimited number of physicians who are not currently located in Buchanan County, so long as less than 20% of the physician's income was derived from patients living in Buchanan County. Final Judgment, Part VIII (B).

Further, the consent decree does not limit the number of new doctors that Heartland can bring into Buchanan County to work for Heartland (as employees or through acquiring their practice), so long as Heartland incurs substantial costs in recruiting the doctors, or gives them substantial financial support or income guarantees. Even though the acquisitions require prior notice to the government, approval will be given if the financial criteria are met. Final Judgment, Part VIII (C).

Finally, the consent decree allows Heartland, with prior DOJ approval, to acquire the practice or employ any physician who finds he or she cannot practice in Buchanan County *unless* hired by Heartland. Final Judgment, Part VIII (D).

The foregoing provisions enable Heartland to further enhance its monopoly power and regional control of physician services, i.e. if independent physicians cannot compete successfully with doctors owned by Heartland, they have to join Heartland to survive. The practical effect of the foregoing provisions is that Heartland's physician base will continue to grow and monopolize the market for primary care physicians in Northwest Missouri and Northeast Kansas, leaving sole practitioners with little choice but to join Heartland or move their practices elsewhere. One can scarcely posit a clearer example of single firm power to control price and exclude competition.

Amicus curiae urges the Court to scrutinize the terms of the proposed Final Judgment and Competitive Impact Statement in light of the fact that neither the DOJ nor the defendants have produced any studies, surveys, or other economic data, or even any affidavits from economists, to show that the proposed decree will result in an increase in competition in the managed care program market, the primary care physician market, or the ancillary services market, or that the decree will prevent Heartland from monopolizing the remainder of those markets. Amicus accordingly urges the Court to require further submissions from the DOJ both by way of expert affidavits and the production of documents and economic data, to explain how permitting Heartland to continue to acquire unlimited numbers of primary care physicians and to continue to allow its physicians to channel Heartland patients to Heartland-affiliated ancillary services providers, can be argued to be in the ''public interest.''

G. The proposed Final Judgment lacks an effective and affirmative Compliance Program and enforcement provisions.

The proposed consent decree lacks accountability provisions to ensure that Heartland hospital patients, and patients of Heartland's physicians, are being given sufficient, unbiased information to allow the patient to make an informed choice among all available ancillary services providers. Moreover, the Compliance Program set forth in the proposed Final Judgment requires only self-reporting of Heartland's proposed acquisitions or other actions covered by the Final Judgment and an annual certification by the defendants that the Final Judgment terms are being adhered to. Final Judgment, § X. Although the DOJ is given what it already has—''access'' to the defendants' records and personnel and the right to obtain written reports from the defendants—there is no *requirement* that written reports be made to the DOJ by any of the defendants, and no requirement that the Department *will* conduct periodic or even annual inspections of books and records and interview of personnel.

Without an affirmative requirement of regular, periodic written reports or government inspections to determine compliance, it will be virtually impossible to determine whether violations of the terms and provisions of the Final Judgment have occurred.

In addition to lacking effective compliance provisions, the proposed Final Judgment provides no judicial mechanism to monitor and enforce the final judgment if its terms are violated. In *United States* v. *Associated Milk Producers, Inc.,* 394 F.Supp. 29 (W.D. Mo. 1975), Judge Oliver addressed these very concerns, finding that ''many persons who may be affected by a consent decree simply do not possess and are not furnished with any information in regard to the manner in which alleged violations of a final judgment entered upon a proposed consent decree are to be brought before the Court for appropriate judicial enforcement proceedings.'' *Id.* at 46. To remedy this situation, Judge Oliver entered a Supplemental Order establishing enforcement and modification procedures to be followed in the event of violations by the defendants of the final judgment.

Similar, appropriate judicial enforcement provisions should be crafted by the Court and included in the Final Judgment, or as a Supplementary Order, in this proceeding.

IV. Conclusion

The proposed Final Judgment is not in the public's interest because it fails to address adequately, much less remedy, the foregoing concerns about the Heartland referral policy, Heartland's physician practice and recruitment efforts, and Heartland's other conduct, which create conditions that facilitate unlawful maintenance of monopoly power by Heartland through anticompetitive and coercive means, conditions conducive to a successful attempt by Heartland to monopolize both the primary care physician market and the ancillary services market in Northwest Missouri and Northeastern Kansas, and conditions that permit Heartland to channel or steer patients in need of ancillary services only to providers it owns, controls, or in which it maintains a significant economic interest.

Amicus strongly urges the Court to strike the incorporated referral policy from the terms of the proposed Final Judgment, or in the alternative to revise the referral policy to conform to the terms and conditions set forth in the ''Model Referral Policy'' proposed by amicus. In addition, amicus urges the court to strengthen the oversight and reporting provisions of the Compliance Program contained in the constant decree, and to incorporate into the consent decree enforcement and modification procedures to be followed in the event of violations by the defendants of the decree.

Finally, amicus respectfully requests the Court to allow amicus to participate in any proceedings or hearings conducted by the Court to determine whether the proposed consent decree is in the public's interest, including oral arguments and presentation of evidence in support of amicus curiae's opposition to the proposed decree.

Respectfully submitted,

ARMSTRONG, TEASDALE, SCHLAFLY & DAVIS

Thomas M. Bradshaw, Mo. 20411

Dianne M. Hansen, Mo. 40356,

1700 City Center Square, 1100 Main Street, Kansas City, Missouri 64105, (816) 221–3420, (816) 221–0786 FAX

and

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One Metropolitan Square, Suite 2600, St. Louis, Missouri 63102–2704, (314) 621–5070.

Attorneys for Amicus Curiae, The Coalition for Quality Healthcare.

Certificate of Mailing

I hereby certify that a true and correct copy of the foregoing document was mailed, postage prepaid, this 1st day of December 1995 to the following counsel of record:

Lawrence R. Fullerton, Esq., Edward D. Eliasberg, Jr., Esq., Antitrust Division, U.S. Dept. of Justice, 600 E Street, NW., Room 9420, BICN Bldg., Washington, DC 20530
Thomas D. Watkins, Esq., Watkins, Boulware, Lucas, Miner, Murphy & Taylor, 3101 Frederick Avenue, St. Joseph, MO 64506–0217
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Dianne M. Hansen

Attorneys for Amicus Curiae, The Coalition for Quality Healthcare.

Western Illinois Home Health Care, Inc.

Gail Hursh,
Chief Professions & Intellectual Property Section, Health Care Task Force, Department of Justice, Antitrust Division, 600 E Street, N.W., Room 9300, Washington, D.C. 20530

Dear Gail Hursh: I am writing in reference to the proposed settlement of United States v. Health Choice of Northwest Missouri, et. al. Case No. 95–6171–CV–SJ–6. I am writing in reference to deep concern over the settlement of this case that could open wider an exclusive market to the hospital based home care agency. They now, even with the present statute, control the referrals out of the hospital with intentional direction to their hospital based home care agency. Opening this door even wider will put them in the drivers seat and force many independent home care agencies out of business. It defeats any strives to force excellent care with the forces of competition, and puts them in control of our health care dollar usage.

In our area, hospitals have even excluded us from visiting previous patients that are hospitalized. We have lost patients that had asked for us stating in misleading terms that I am sending your home care nurse out; to their dismay when they arrive home they have never met that nurse or the hospital agency.

I had read once that there was a movement to require hospitals to publicize a list of discharges and where the referral was made and to incorporate fines for misuse of their system. I would hope we would go in that direction in some fashion to prevent what was not ever intended; exclusive control of the health care system by certain providers.

I appreciate your sincere review of this point of view and concern.

Sincerely,

Barbara Byers,

Chief Executive Officer, Western Illinois Home Health Care Inc.

Delta County Memorial Hospital

100 Stafford Lane, P.O. Box 10100, Delta, Colorado 81416–5003, (970) 874–7681

November 30, 1995.

Gail Kursh,
Chief Professions & Intellectual Property Section, Health Care Task Force, Department of Justice, Antitrust Division, 600 E St. N.W., Room 9300, Washington, D.C. 20530

Ms. Kursh, I recently read the article in ''Home Health Line'' regarding the judgement for the United States vs Health Choice of Northwest Missouri, Inc., et al., Case No. 95–6171–CV–SJ–6, regarding the choice of Home Health Agencies for hospitalized patients.

The article was very informative and very timely for our institution. We have a hospital-based Home Health agency and in the past year there has been several new agencies that have moved into the area. Generally, when our physicians order Home Health it will be the hospital's agency, since they are familiar with the nursing staff, their practices and the quality of care they provide.

Currently, our Discharge Planners will inform the patient the physician has ordered Home Health and that the hospital has it's own agency. If the patient requests other options for Home Health, we provide them with a written list of the other agencies in the area, then inform them that this will have to be discussed and approved by the physician, since he is the one who have to deal with a different agency. So far, this has worked well.

We have been approached by outside Home Health agencies requesting to sit in our Discharge Planning Conferences, which I find totally inappropriate. That is like having a stranger come in off the streets and hear about our patients, their medical condition or home situation, a total breech of patient confidentiality. Our hospital's Home Health agency does participate in our Discharge Planning Conferences, since many of the patients are currently their clients and any new referrals will probably go to them.

I certainly do not agree with a rotation system either. Discharge Planning in our community is difficult enough without having the added complication of keeping track which agency is next on the list. Along with the fact we have no first-hand knowledge about the quality of care they provide. Nor do I agree with allowing them access to our patients in the hospital. These patients are here because they are sick, they certainly do not want or need a ''Salesman'' pounding on their door. For one thing the patient may not even need Home Health. Secondly, I am sure our patients do not want four or five agency personnel knowing about their medical condition or that they are even in the hospital. AGAIN, WHAT HAPPENED TO PATIENT CONFIDENTIALITY????

I think if these Home Health agencies want to expose the public to the availability of other Home Health Care agencies in the area, they need to advertise like every other business. That way patients may ask for their particular agency if or when the need arose.

Thank you for this opportunity to express our concerns on this matter.

Sincerely,

Ramona Frazier,

QA/Risk Manager.

Joyce Gillespie,

Marti Svensen

North Georgia Home Health Agency, Inc.

Main Office, 1875 Fant Drive, Ft. Oglethorpe, Georgia 30742, 706/861–5940

December 1, 1995.

Gail Kursh,
Chief, Professional & Intellectual Property Section/Health Care Task Force, Department of Justice, Antitrust Division, 600 E. Street, N.W., Room 9300, Washington, D.C. 20530.

Re: *Comments on Proposed Final Judgement: United States vs. Health Choice of Northwest Missouri, Inc., et al., Case No. 95–6171–CV–SJ–6 in the U.S. District Court for the Western District of Missouri*

Dear Ms. Kursh: As a home health care provider I have first-hand knowledge of the subject matter the Department of Justice is dealing with in the above referenced matter. I also understand the influence a hospital can exert in a patient's selection of post-hospital ancillary services, including the selection of a home health care provider. For these reasons, I have reviewed and studied the DOJ's recommended home health, DME and hospice referral policy for Heartland Hospital.

In the interest of protecting patient choice (which is guaranteed by both Federal and State laws,) as well as maintaining fair competition consistent with the antitrust laws and FTC regulations, I respectfully submit that the final proposed judgement (recommended policy) be modified as such:

- Strengthen limitations on the hospital's ability to refer its patients to its own hospital-based components;
- Require the hospital to provide patients with an updated list of Medicare/Medicaid providers in the community:
- Require the hospital to use a rotation system, which assures equitable referrals to all providers in the area;
- Require the hospital to permit (on their premises, during normal working hours) representatives of freestanding providers—other than their own hospital-based components—to visit their patients who have been admitted for hospitalization; and to expose the patient population to the availability of outside services as well;
- Make the hospital publicly post its daily referrals to both its hospital-based entities and to other providers in the community.

On behalf of our home health agency and the patients we serve, we respectfully ask that you give these comments due consideration. These issues are of even more concern in today's era of health care and provider consolidation.

Sincerely,

Sherylon Smith,

Administrator.

SS:so

Lutheran Home Care Service, Inc.

2700 Luther Drive, Chambersburg, PA 17201–8132, VOICE/TDD/TT/FAX, 717/264–8178 and 762–3996

December 1, 1995.

Gail Kursh,
Dept. of Justice, Antitrust Division, 600 E. St., N.W., Room 9300, Washington, D.C. 20530

Dear Ms. Kursh, I am writing to register a complaint regarding the proposed referral policy for home health, DME and hospice recommended by the Department of Justice. We have been the primary provider of home health and hospice within our community for 18 years. Due to philosophical differences between our agency and the local hospitals we did not become the hospitals home health provider. The two small local hospitals brought in another home care agency from outside of our area. This provider already has an advantage over us since they have formed an alliance with the hospitals. Our hospitals, have tried to be very fair in offering choices to the patients, however, if this new referral policy is approved then we are at a significant disadvantage.

Lutheran Home Care Services, Inc. supports the modifications as proposed by the Coalition for Quality Healthcare. Those of us who have provided faithful quality services, as well as hundreds of thousands of dollars in benevolent care over many years should not be put at significant risk which would occur if this policy were passed. We are doing our part to try and keep our share of the market. We should not be penalized by a policy that clearly favors the hospital based agencies.

Sincerely,

Diane M. Howell,

Executive Director.

November, 27, 1995.

Gail Kursh,
Chief, Professions & Intellectual Property Section/Health Care Task Force, Dept. of Justice, Antitrust Division, 600 E St., NW Room 9300, Washington, DC 20530

Dear Ms. Kursh: I am an employee in a small, rural freestanding home health care agency. I have read with great dismay the recent DOJ ruling in the matter of United States v. Health Choice of Northwest Missouri Inc.

In our own community, a local hospital-based program has instituted unfair practices which have practically eliminated competition in our service area.

I know that in our government, numbers count. Let me add my voice to the many who will ask you to modify the decision to include the following language:

fl Strengthen limitations on a hospital's ability to refer its patients to its own hospital-based components;

fl Require the hospital to use a rotation system, which assures equitable referrals to all providers *who offer the same level of certification and/or accreditation, or higher* in the area—Hospitals are well aware of the accreditation of local providers;

fl Require the hospital to permit (on their premises, during normal working hours), representatives of freestanding providers;

fl Make the hospital publicly post its daily referrals to both its hospital-based entities and to other providers in the community.

Sincerely yours,

Gaina Keljawski.

Tugaloo Home Health Agency, Inc.

P.O. Box 77, Lavonia, Georgia 30553, (706) 356–8480

December 1, 1995.

Gail Kursh,
Chief, Professional and Intellectual Property Section/Health Care Task Force, Department of Justice, Antitrust Division, 600 E. St., NW., Room 9300, Washington DC 20530

Re: *Comments on Proposed Final Judgment United States* v. *Health Choice of Northwest Missouri, Inc., et al., Case No. 95–6171–CV–SJ–6 in the U.S. District Court for the Western District of Missouri*

Dear Ms. Kursh: As a home health care provider I have first-hand knowledge of the subject matter the Department of Justice is dealing with in the above referenced matter. I also understand the influence a hospital can exert in a patient's selecting of post-hospital ancillary services, including the selection of a home health care provider. For these reasons I have reviewed and studied the DOJ's recommended home health, DME and hospice referral policy for Heartland Hospital.

In the interest of protecting patient choice (which is guaranteed by both Federal and State laws) as well as maintaining fair competition consistent with the antitrust laws and FTC regulations, I respectfully submit that the final proposed judgment (recommended policy) be modified as such:

- Strengthen limitations on the hospital's ability to refer its patients to its own hospital-based components;
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- Require the hospital to use a rotation system, which assures equitable referrals to all providers in the area;
- Require the hospital to permit (on their premises, during normal working hours) representatives of freestanding providers—other than their own hospital-based components—to visit their patients who have been admitted for hospitalization; and to expose the patient population to the availability of outside services as well;
- Make the hospital publicly post its daily referrals to both its hospital-based entities and to other providers in the community.

On behalf of our home health agency and the patients we serve, we respectfully ask that you give these comments due consideration. These issues are of even more concern in today's era of health care and provider consolidation.

Sincerely,

Captain C.C. Dudley,

Executive Director.

November 27, 1995.

Gail Kursh,
Chief, Professions & Intellectual Property Section/Health Care Task Force, Dept. of Justice, Antitrust Division, 600 E St., NW., Room 9300, Washington, DC 20530

Dear Ms. Kursh: I am an employee in a small, rural freestanding home health care agency. I have read with great dismay the recent DOJ ruling in the matter of United States v. Health Choice of Northwest Missouri, Inc.

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fl Require the hospital to use a rotation system, which assures equitable referrals to all providers *who offer the same level of certification and/or accreditation, or higher* in the area—Hospitals are well aware of the accreditation of local providers;

fl Require the hospital to permit (on their premises, during normal working hours), representatives of freestanding providers;

fl Make the hospital publicly post its daily referrals to both its hospital-based entities and to other providers in the community.

Sincerely yours,

L. Patterson

November 13, 1995.

Chief Gail Kursh,
Profession & Intellectual Property Section, Health Care Task Force, Department of Justice, Antitrust Division, 600 E St., NW., Room 9300, Washington, DC 20530

Dear Chief Kursh: This letter is to provide my comments on the proposed final judgement for United States v. Health Choice of Northwest Missouri, Inc. et al., Case No. 95–6171–CV–SJ–6 in the U.S. District Court for the Western District of Missouri.

I have read the Department of Justice's recommended home health, DME and hospice referral policy for Heartland Hospital and as a home health provider I find it continues to impede fair competition and preserves the hospital monopoly on referrals to home care.

My background encompasses home care from public health to proprietary agencies. I have witnessed hospital-based agencies take on case overloads that prevents adequate care being provided. A prime example is Medicare patients requiring skilled nursing and home health aide services. In the Omaha area there is a severe shortage of home health aides so the patient is advised they are entitled to two ''bath visits'' per week. The patient often infers this is all Medicare allows when instead it is all that can be staffed. The assumption cannot be made that the agency is just being conservative with Medicare because often the skilled nursing and therapies are maximized when the patient really needs more assistance with personal care. The purchase power of Medicare is severely decreased when one agency provides a ''bath visit'' for one hour

versus an agency that can provide staff to provide a two hour visit giving more personal care. With the lack of competition and patients not knowledgeable of their benefits we will continue to see our health care dollars erode.

I do not feel this present policy goes far enough to encourage fair competition. I would like to see the final judgement modified to strengthen limitations on the hospitals ability to refer its patients to its own health care agencies. I think the hospital should be required to use a rotation system which assures equal referrals to all providers and allow the freestanding providers to visit the hospitalized population to expose them to the availability of outside services.

Thank you for your consideration on this issue.

Glenelle Kruse,

208 N. Chestnut, Glenwood, Iowa 51534, 712–527–4372.

Cabarrus County Home Health

28 Branchview Dr., NE, P.O. Box 707, Concord, N.C. 28026–0707, Phone (704) 788–8180, Fax (704) 788–9876

November 30, 1995.

Gail Kursh,

Chief, Professional & Intellectual Property Section/Health Care Task Force, Department of Justice, Antitrust Division, 600 E Street, NW, Room 9300, Washington, DC 20530

Re: *Comments on Proposed Final Judgment: United States v. Health Choice of Northwest Missouri, Inc., et al., Case No 95–6171–CV–SJ–6 in the U.S. District Court for the Western District of Missouri*

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In the interest of protecting patient choice (which is guaranteed by both Federal and State laws) as well as maintaining fair competition consistent with the antitrust laws and FTC regulations, I respectfully submit that the final proposed judgment (recommended policy) be modified as such:

* Strengthen limitations on the hospital's ability to refer its patients to its own hospital-based components;

* Require the hospital to provide patients with an updated list of Medicare/Medicaid providers in the community;

* Require the hospital to use a rotation system, which assures equitable referrals to all providers in the area;

* Require the hospital to permit (on their premises, during normal working hours) representatives of freestanding providers—other than their own hospital-based components—to visit their patients who have been admitted for hospitalization; and to expose the patient population to the availability of outside services as well;

* Make the hospital publicly post its daily referrals to both its hospital-based entities and to other providers in the community.

On behalf of our home health agency and the patients we serve, we respectfully ask that you give these comments due consideration. These issues are of even more concern in today's era of health care and provider consolidation.

Sincerely,

JoAnn Reed,

Director.

Emerald Care

2923 Rousseau Court, Gastonia, NC 28054, Fax: 704–864–3673, Toll-Free Tel: 1–800–427–1143, Telephone: 704–867–1141

December 1, 1995.

Gail Hursh,

Chief Professions & Intellectual Property Section, Health Care Task Force, Department of Justice, Antitrust Division, 600 E. Street, NW., Room 9300, Washington, D.C. 20530

Re: United States versus Health Choice of Northwest Missouri, et al., Case Number 95–6171–CV–SJ–6

Dear Ms. Hursh: I have received a copy of your recommended Home Health, Durable Medical Equipment and Hospice Referral Policy for Heartland Hospital and I have reservations about your recommended action. Please consider the following:

• Hospitals now own physician practices and in our area, our community-based hospital owns several physician practices and is planning to build a five-story building for physician offices. The physicians, therefore, are strongly encouraged to refer to the hospitals' home health agency. Because of the financial-ownership relationship, this ''encouragement'' is more like a demand or directive. This type of relationship/requirement approaches a conflict of interest issue.

Concerning Heartland Hospital not being able to recommend another home health agency:

• A community-based hospital has a responsibility to maintain information on pertinent resources for the education of their staff. While no hospital can fully guarantee or totally recommend the services of any large home health agency, including their own, they can and should give patients an informed choice based upon written or verified information from the established, licensed and accredited home health agency, home medical equipment company, pharmacies, etc. Your statement implies that since a home health agency is not part of a hospital, i.e., Heartland, the discharge planner cannot recommend them.

I applaud your effort in emphasizing *patient choice* in the referral/selection of a home health agency. Patients need to be informed of the resources such as licensed/accredited home health agencies before a decision is made. Physicians also need the ability to make a choice that is based on the good of their patients and what their patients want without possible recrimination by the hospital, with whom the physician may have an employee relationship.

Many patients who need home health services are elderly and vulnerable. The idea that these fragile persons have to ask for choices of available ancillary services, after being identified as needing these services, is not fair to the client.

I thank you for the opportunity to comment. If you have any questions please do not hesitate to call.

Sincerely,

Eileen A. Klimkowski,

Executive Director.

Cooper Home Health, Inc.

51 North Side Square, Cooper, Texas 75432, 903–395–2811, 800–395–5357, FAX 903–395–2766

November 30, 1995.

Gail Kursh,

Chief, Professions & Intellectual Property Section/Health Care Task Force, Department of Justice, Antitrust Division, 600 E St., NW., Room 9300, Washington, DC 20530

Re: *United States* v. *Health Choice of Northwest Missouri, Inc., et al.,* Case No. 95–6171–CV–SJ–6

Dear Chief Kursh: As an owner/administrator of a private home health agency in Texas, I would like to comment on the above referenced case and ask for consideration for small business owners. It appears that this case reflects the same problems experienced by privately owned home health agencies in competition with hospital-based agencies. In short, hospitals have a built-in referral base and are reluctant to refer patients to outside home care agencies for obvious reasons. I personally am familiar with numerous examples in which patients were not given a choice, and some were even misled into thinking their physician had made the choice for them. In reading the proposed procedure developed by Heartland Health System, I am convinced that approval of this procedure will solidify the power of hospital discharge planners to exclude outside agencies and refer exclusively to their own.

The proposed procedure is also in direct conflict with the Texas Association for Home Care Code of Ethics which states:

• Agencies shall honestly and conscientiously cooperate in providing information about referrals and shall work together to assure comprehensive services to clients and their families.

• Member agencies shall not engage in coercive or unreasonably restrictive exclusionary behavior which would restrict or impede consumer choice of provider agencies. A member agency or related entity that provides a screen to clients for home care referrals shall not use that position to influence a client's choice and to direct referrals to itself, and shall inform clients of the availability of home care providers and advise clients that they have the right to choose the provider they prefer.

The proposed procedure would allow Heartland Health System to present information regarding its service without any mention of other providers. It is obvious this procedure does not allow the patient to make

an informed choice, especially if he does not express a preference. At a minimum, the discharge planner should be required to make available a listing of all providers in the patient's community without showing preference to any provider.

I would sincerely appreciate your careful consideration of this case, and hope that you can be sympathetic to the position of privately owned businesses. Many current practices are already in violation of the antitrust laws, and approval of Heartland's proposed procedure would give hospitals and other health systems the ability to restrict trade even further. Thank you for your concern.

Respectfully,

Nicki J. Beeler,

Administrator.

At Home Health Care

900 Veterans Blvd., Suite 230, Redwood City, California 94063, (415) 368–1182, FAX (415) 368–1184

December 2, 1995.

Ms. Gail Kursh,

Chief, Professional & Intellectual Property Section/Health Care Task Force, Department of Justice, Antitrust Division, Room 9300, 600 E. Street, N.W., Washington, D.C. 20530.

Dear Ms. Kursh: Below are comments on the proposed final judgement for United States *v.* Health Choice of Northwest Missouri, Inc., et al., Case No. 95–6171–CV–SJ–6.

Section II.B.2. and 3. of the referral policy:

De facto, the result will be no true patient choice. Before long, no other qualified provider will ever hear about potential clients they could be caring for. If the hospital is allowed to be the first and only provider to ''sell to'' the sick and dying, the frail elderly, and their beleaguered families, few other providers will get referrals. This is a fox in the hen house situation.

We say this because hospitals, being almost universally in a strapped financial condition, put enormous pressure on their self-owned home care agencies. In our area, they are nothing less than predatory. They discard the literature we deliver to the hospital, they cajole the doctors at hospital staff meetings, and they disguise home care agency nurses as hospital-employees, i.e., Discharge Planners.

Earlier this year, we received a referral from the ALS foundation (Lou Gehrig's Disease) and the patient's family. When our nurse went to the hospital for the discharge planning session, the hospital's ''discharge planner'' was actually a nurse from the hospital-based home care agency. In fact, she made the comment that she didn't quite know how to handle the situation; she said she'd never given a patient to another agency before.

Usually, the ''discharge planners'' are more discreet than this, but they invariably believe that all hospital patients belong to them. If they ''release'' a patient to another agency, they believe it is a result of their largesse.

A common ploy is ''I'm so sorry Mrs. So-and-so, but the paperwork is already made out. Just try us for the first day. If it doesn't work out, you can change agencies tomorrow.'' The normal reply from a sick, elderly person is, ''I don't want to be a bother to anyone.'' A frail, fatigued, 85-year old should not be expected become an informed consumer at the time of discharge.

Handing the patient a phone book is completely unacceptable. The very least they could do is provide them a ''Help at Home'' booklet or ''Senior Handbook'' published, if not by the hospital itself, then by the county of residence. As written, this art of the recommended referral policy would be insulting to the patient.

We urge the Department of Justice to make sure that Heartland is not made the fox in the hen house. Even more cogent, however, is the Department's moral obligation to insure that American citizens, at their most vulnerable moment, are not taken advantage of.

Sincerly yours,

Robert J. Brock,

Vice President.

cc: California Association for Health Care at Home, Attn: Connie Little, RN

November 30, 1995.

Gail Kursh,

Chief, Professions & Intellectual Property Section/Health Care Task Force, Department of Justice, Antitrust Division, 600 E St., NW, Room 9300, Washington, DC 20530.

Re: U.S. *v.* Health Choice of N.W. Missouri, Inc., Case No. 95–6171–CV–SJ–6

Dear Chief Kursh: As a social worker for a private home health agency in Texas, I would like to comment on the above mentioned case and ask for consideration for patient rights to informed choices. Hospitals have a built-in referral base and are reluctant to refer patients to home health agencies other than their own. In reading the proposed procedure developed by Heartland Health System, I am convinced that approval of this procedure will give discharge planners the power to refer exclusively to their own agencies. The proposed procedure is also in direct conflict with the Texas Association for Home Care code of Ethics. Patients must have the right to make a informed choice of health care. Thank you for your concern.

Respectfully,

Gregory Grinstead.

November 27, 1995.

Gail Kursh,

Chief Professions & Intellectual Property Section/Health Care Task Force, Dept. of Justice, Antitrust Division, 600 E St. NW Room 9300, Washington, D.C. 20530

Dear Ms. Kursh: I am an employee in a small, rural freestanding home health care agency. I have read with great dismay the recent DOJ ruling in the matter of United States v. Health Choice of Northwest Missouri Inc.

In our own community, a local hospital-based program has instituted unfair practices which have practically eliminated competition in our service area.

I know that in our government, numbers count. Let me add my voice to the many who will ask you to modify the decision to include the following language:

fl Strengthen limitations on a hospital's ability to refer its patients to its own hospital-based components;

fl Require the hospital to use a rotation system, which assures equitable referrals to all providers *who offer the same level of certification and/or accreditation, or higher* in the area—Hospitals are well aware of the accreditation of local providers;

fl Require the hospital to permit (on their premises, during normal working hours), representatives of freestanding providers;

fl Make the hospital publicly post its daily referrals to both its hospital-based entities and to other providers in the community.

Sincerely yours.

Margaret Klan,

4 Oakridge Drive, Marquette, MI 49855.

Richmond Healthcare Consultants, Inc.

303 South A Street, Richmond, IN 47374, (317) 935–4677

November 30, 1995.

Gail Hursh,

Chief, Professions & Intellectual Property Section/Health Care Task Force, Department of Justice, Antitrust Division, 600 E Street, N.W. Room 9300, Washington, D.C. 20530

Re: *United States v. Health Choice of Northwest Missouri, et al.,* Case No. 95–6171–CV–SJ–6, United States District Court for the Western District of Missouri

The proposed settlement would unduly burden non-hospital based home care agencies.

As a President of two non-hospital owned agencies in a 78,000 population community with one hospital, my agencies, as well as the other non-hospital agencies, have to scratch and dig to PRESERVE our clients who become hospitalized. The hospital has been documented pressuring our patients to change to the hospital owned agency.

We have clients who specifically request us by name and they get the hospital based agency in spite of their requests. They voice dissatisfaction to their doctors who are also under pressure by the hospital (via their privileges) to refer only to hospital based agency services.

We (the non-hospital based agencies) must constantly monitor their activities to prevent duress to our patients.

A settlement as described would in my opinion let free the modicum of restraint the hospital maintains now due to the existing anti-trust regulations.

There would be no holds barred, no competition for the hospital and I see even now the effects of lesser quality provided by some hospital based services becoming even less quality oriented without strict enforcement of anti-trust activities. The hospital presently takes the bulk of all discharged clients as it is.

I plead for enforcement of the anti-trust regulations, not a lessening of them. On behalf of my staff and clients, I thank you for your time.

Sincerely,

Robin King,

Administrator.

RK/sf

Cooper Home Health, Inc.,

51 North Side Square, Cooper, Texas 75432, 903–395–2811, 800–395–5357, FAX 903–395–2766.

November 30, 1995.

Gail Kursh,

Chief, Professions & Intellectual Property Section/Health Care Task Force, Department of Justice, Antitrust Division, 600 E St., N.W., Room 9300, Washington, D.C. 20530

Re: United States *v.* Health Choice of Northwest Missouri, Inc., et al., Case No. 95–6171–CV–SJ–6

Dear Chief Kursh: As an owner/DON of a small, private home health agency in Texas, I would like to take this opportunity to comment on the above case. This case reflects a growing problem for those of us in the private industry. There is fierce competition in the home health industry for patient referrals on the whole. Most hospitals now have their own home health departments. These hospitals have a built in referral system and are reluctant to refer patients to competing agencies for obvious reasons. Currently discharge planners are required to give patients a choice when a referral for home health is ordered by the physician. Some discharge planners are not giving patients a choice now due to pressures from their administration to refer to the hospital home health. Should the proposed procedure be approved, there will be very little, if any, incentive for outside referrals to be made. This will effectively exclude private home health agencies from receiving any referrals from hospitals.

The main focus of those of us in the health care industry should always be the welfare of the patient. The patient must always be given a choice and assisted with whatever information he or she needs to make that choice. This proposed process, as it is currently written, would remove patient welfare as a top priority and be replaced by the desire for increased revenue/volume.

I feel that at the very least, the discharge planners must give patients a list of home health agencies in the area. I also feel that patients should be assisted to make decisions about different agencies; i.e.: agencies that may specialize in certain areas of service.

Please consider all of the above when making a decision about this proposed procedure. The relationship between hospitals and home health agencies is strained now due to competition for patients. The passing of this procedure would only prove to give hospitals a greater monopoly than they currently have further straining relationships and shoving patient welfare to a far, distant priority.

Thank you for your time and concern in this matter.

Sincerely,

Tina Janes,

DON.

Tami L. Becker, R.N., B.S.N.,

14 Zanella Dr., Emmitsburg, Md. 21727

November 15, 1995.

Gail Kursh,

Chief, Professions & Intellectual Property Section/Health Care Task Force, Dept. of Justice, Antitrust Division, 600 E Street, Northwest—Room 9300, Washington, D.C. 20530

Dear Gail: I am writing in response to the article published in * * * home health line, November 13, 1995, regarding the final judgement for United States v. Health Choice of Northwest Missouri, Inc., et al., Case No. 95–6171–CV–SJ–6.

First of all, I wish to express my thanks to the Department of Justice for accepting written comments on its proposed final judgement in this precedent setting case.

As a supervisor for a non-profit home health agency serving a small, but rapidly growing rural community, I have seen considerable changes in the delivery of home health care over the thirteen years I have worked for this company. Our agency has been in business for over twenty years providing care to the residents of our county, and has taken pride in it's ability to change and grow to meet the needs of the area. We have been proactive in stream-lining our services to become more efficient and cost effective, while assuring a continued high quality of care. Despite our small size, we have been able to negotiate with several managed care organizations winning contracts to provide care to the local residents. This enables persons within our county boundaries to continue to have a choice between our agency and the large, unfamiliar home health agencies located in other counties or states.

We are well aware of the practices of many of these for-profit home health agencies, which contend the ability to provide services to a large geographic area in order to win managed care contracts; but, in reality have no providers in many of the rural areas which they service. Frequently, we are called by area residents who may have had our services in the past, complaining that their physician prescribed nurse, therapy, or aide services prior to their discharge from a hospital. Once they were home, they found that only one or two of the services were provided in a timely manner, as the other service(s) were unavailable due to ''staffing shortages''. In one case, a patient who had been hospitalized for a hip replacement waited more than a week for therapy. In another case, an immobilized patient never received aide services to which he was entitled, leaving his elderly spouse solely responsible for his personal care needs. Both of these patients had advised their referring hospitals that they wished to be referred to our agency, but were told that they had to use the agency with which the hospital was contracted. Quite obviously, these patients both received less than adequate care, when there were local agencies willing and able to provide the service.

In most cases, it is the vulnerable elderly population which become the victims in the competition between home health agencies. Even if they are mentally and physically able to understand their rights when it comes to choosing medical care, they are afraid to speak up, for fear of what will happen if they need to seek care in a particular facility in the future. Furthermore, we are seeing an increase in the number of patients seeking assistance after they have been discharged from their home health agency. The home health agency, having exhausted the patient's home health insurance benefit, release the patient, to their own capabilities. It is then expected that we, the non-profit home health agency, will pick up where the for-profit agency left off and provide uncompensated care. While we are committed to caring for the indigent, un-insured and under-insured of our county, it is only through the small margin of profit reimbursement we receive from the insured clients, that we can continue to provide the charity care for which we are known. As many of the patients referred to us are non-pay or partial pay on admission to our program, it does not take long to exhaust our resources.

We have neither asked for, or received a governmental subsidy to assist in the provision of our services for over two years. Therefore, it does not seem reasonable to allow the for-profit agencies to discharge patients with continuing home health needs, after having depleted their insurance benefits.

The referrals we receive have been won by our continued reputation for excellence within our community. We have no money for marketing. Most of our referrals come by word of mouth, either from a patient, physician or a referral source with whom we have worked in the past. Despite the evolution of managed care, we continue to subsist based upon our willingness to streamline and cost cut. However, a form of competition which we will not survive is the ability of hospitals to form home health agencies, and retain all of their paying referrals. Our local community hospital is now in the process of forming a home health agency, which we have supported from the onset. We feel that while another home health agency in our county will most definitely impact our referral base, it is important that all community hospitals augment their outpatient services to remain viable. Never-the-less, if that hospital or any hospital is allowed prevent patients from learning of and utilizing other agencies, we will have no chance for survival. This, in my opinion, is not fair market competition but rather the creation of a monopoly.

Thank you again for the opportunity to express my concerns with regards to this issue.

Sincerely,

Tami L. Becker.

Texas Association for Home Care

3737 Executive Center Drive, Suite 151, Austin, Texas 78731, (512) 338–9293

December 1, 1995.

Gail Kursh,

Chief, Professions & Intellectual Property Section, Health Care Task Force, Department of Justice, Antitrust Division, 600 E St. NW., Room 9300, Washington, DC 20530

Re: United *v.* Health Choice of Northwest Missouri, Inc. et al, Case No. 95–6171–CV–SJ–6, District Court for the Western District of Missouri

Dear Ms. Kursh: The Texas Association for Home Care represents over 650 home and community support services agencies throughout Texas providing home health, hospice and personal assistance services. Our membership includes freestanding and hospital based, as well as proprietary and non-profit agencies. We have provided all of our members a copy of the proposed final judgment which outlines a policy for patient referral by the hospital system to home care and other ancillary services.

The paramount questions in determining acceptability of the referral policy should be (1) is the patient advised that he has a choice of providers for ancillary services? (2) is adequate information made available for the patient to make an informed selection? The sequence in which the information is provided with relationship to the provisions of information about the hospital's ancillary services is also a key factor in determining acceptability of the policy.

The Texas Association for Home Care unanimously passed a Code of Ethics in September 1995 in order to promote the provision of high quality home and community support services to patients by member agencies. Two provisions in our Code of Ethics are relevant to this case:

- Agencies shall honestly and conscientiously cooperate in providing information about referrals and shall work together to assure comprehensive services to clients and their families.
- Member agencies shall not engage in coercive or unreasonably restrictive exclusionary behavior which would restrict or impede consumer choice of provider agencies. A member agency or related entity that provides a screen to clients for home care referrals shall not use that position to influence a client's choice to direct referral to itself, and shall inform clients of the availability of home care providers and advise clients that they have the right to choose the provider they prefer.

We will appreciate your serious consideration of all comments that you receive from the industries affected to protect the patient's freedom of choice and to prevent unreasonable restraint of trade.

Sincerely,

Anita Bradberry,

Executive Director.

Diana L. Gustin, Attorney at Law

Plaza Tower, Suite 2001, 800 South Gay Street, Knoxville, Tennessee 37929, Telephone (615) 523–5545, Telecopier (615) 523–4738

November 30, 1995.

Ms. Gail Kursh,

Chief, Professions & Intellectual Property Section, Health Care Task Force, Department of Justice, Antitrust Division, 600 E. St., N.W., Room 9300, Washington, D.C. 20530

Re: Written Comments on the proposed final judgment for: *United States v. Health Choice of Northwest Missouri, Inc., et al.* Case No. 95–6171–CV–SJ–6 in the U.S. District for the Western District of Missouri.

Dear Ms. Kursh, I am writing in response to the article in the newsletter of Home Health Line on November 13, 1995, which noted that providers are being given a chance to comment on the proposed final judgment for the above captioned matter. I represent several home health care agencies, one of which contacted me concerning this matter. I have reviewed the proposed order with my client and discussed the ramifications of the changes which might result in hospital discharge policies as a result of this litigation. My client and I do not believe the policy endorsed by the DOJ goes far enough to protect independent freestanding home health care agencies from unfair competition by hospitals. I believe the final judgment should be modified in accordance with the Coalition for Quality Healthcare, the group of St. Joseph health care providers which proposed that the final judgment be modified to:

—Strengthen limitations on hospital's ability to refer its patients to its own hospital-based components;

—Require the hospital to use a rotation system which assures equitable referrals to all providers in the area;

—Require the hospital to permit representatives of freestanding providers to visit the hospital patients who have been admitted for hospitalization and thereby expose the patient population to the availability of outside services;

—Make the hospital publicly post its daily referrals to both its hospital-based entities and to other providers in the community.

In addition to endorsing the changes suggested by the Coalition, I would like to take this opportunity to comment on some other concerns in regard to the DOJ's recommended referral policy.

First of all, I believe it is extremely important to protect the patient's right to be informed and to participate in the planning of their own care. In fact, 42 Code of Federal Regulation Section 484.10 codifies the patients's right to be informed, in advance about the care to be furnished and of any changes in the care to be furnished. I believe this requires more than allowing a physician to order an Ancillary Service, specify the provider to be used and *then* ask the patient if this is acceptable. The patient should be educated about the available choices in order to make an informed decision. Requiring hospitals to permit representatives of freestanding providers to visit the hospital patients who have been admitted for hospitalization and thereby expose the patient population to the availability of outside services would accomplish this objective. Requiring hospitals to publicly post daily referrals to both its hospital-based entities and to other providers in the community would be a simple and easy way to monitor the hospitals' referral practices.

Secondly, the disclaimer contained in the DOJ's recommended home health, DME and hospice referral policy could be quite misleading. The social worker, who is asked a *second* time, about other providers ''should indicate that Heartland has done no independent review or evaluation of these providers and cannot speak to the quality of care they provide***''

This infers that other agencies' quality of care is not equal to (or better than) the hospital's quality of care. This suggestion may be used to frighten the patient into choosing the hospital affiliated agency. Since quality assurance and condition of participation surveys are performed on a regular basis upon all home health care agencies which participate in the Medicare program, it should be *presumed* that those agencies which have maintain their license in good standing have the level of quality care necessary. In short, quality controls exist for freestanding agencies which are not being mentioned to the patient yet the suggestion is being made that providers, other than the hospital affiliated provider, could be lacking in quality in comparison thereto. This type of misleading disclaimer could be construed as unfair competition.

Finally, the application of the prohibition on self-referral should be considered in this context. 42 U.S.C. Section 1320a–7b states that whoever knowingly and willfully solicits or receives any remuneration directly or indirectly, overtly or covertly, in cash or in kind, in return for referring an individual to a person for the furnishing or arranging for the furnishing of any items or service for which payment may be made in whole or in part under Title XVIII or a State health care program, shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both. This section of the Medicare Act could be read to find that payment of wages to the hospital social worker or discharge planner or referring physician would qualify as acceptance of remuneration for referral to the hospital affiliated provider. In fact, the very abuse this statute seeks to prohibit could occur if hospitals are continually allowed to automatically refer all ancillary services to their own affiliated providers. There is an incentive for overutilization being perpetuated by allowing a hospital to automatically refer to itself.

Based upon all of these points, I strongly suggest consideration of language which would provide additional safeguards in the referral policy at issue in this litigation. Thank you for the opportunity to provide comments on this subject. If you have any questions concerning this letter, please feel free to contact my office.

Sincerely,

Diana L. Gustin.

Villa-Care Home Health, Professional Home Health Services

1100 Bridgewood Dr., Suite 110, Fort Worth, Texas 76112, (817) 451–3654, Metro (817) 429–9229, Fax (817) 451–3806

November 30, 1995.

Gail Kursh,

Chief, Professions & Intellectual Property Section/Health Care Task Force, Department of Justice, Antitrust Division, 600 E Street, NW., Room 9300, Washington, DC 20530.

Re: United States v. Health Choice of Northwest Missouri, Inc., et al., Case No. 195–6171–CV–SJ–6, U.S. District Court for the West District of Missouri.

Dear Ms. Kursh: As a home health provider, the proposed final judgment for above referenced case creates serious questions for us. From the provisions I have read, it seems that this proposal from Heartland Health System would continue to allow Heartland to refer to their own ancillary services with few exceptions. This could, and probably would, have a negative impact on private, free-standing ancillary services of all kinds.

Texas Association for Home Care embraces a code of ethics that includes cooperation between agencies in providing information about referrals and the provision of comprehensive services to clients and their families. Also included in this code is that member agencies will not engage in coercive or unreasonably restrictive exclusionary behavior which would restrict or impede consumer choice of provider agencies. The proposed final judgment would be unreasonably restrictive, exclusionary, coercive, and as a result, detrimental to any agency not attached to a hospital or other large health care system.

''If the patient has no preference, a referring person shall indicate that Heartland has an excellent, fully accredited Ancillary Service that is available to the patient, and the appropriate Heartland brochure may be given'' is *not* allowing the patient the right to choose. The patient remains uninformed about options in the community, unless by some chance s/he has more knowledge than the average patient about resources available.

It is the obligation, duty and responsibility of free-standing ancillary services to provide information to the healthcare system regarding their qualifications which may include Medicare certification, JCAHO accreditation, etc. It should also be the obligation, duty and responsibility of the healthcare system to make that information available to all patients. In light of the changes being proposed in the Medicare payment method to home health agencies, it is the fear of many of the free-standing agencies that the healthcare systems will take only those patients felt to be ''cost effective,'' and all others will be referred out.

Too many times the elderly population is neglected or abused by healthcare providers. To pass this final judgment would be another opportunity for huge healthcare systems to benefit financially from the unsuspecting public.

I appreciate this opportunity to express my feelings regarding this issue and hope that the final judgment will be more favorable to the patient and the independent ancillary service providers.

Sincerely,

Meredith H. Tracy,

Director of Nursing.

Total Professional Health Care, A Subsidiary of NuMED Home Health Care, Inc.

5770 Roosevelt Blvd., Suite 700, Clearwater, FL 34620, (813) 531–0299, (813) 530–4912 Fax

November 30, 1995.

Gail Kursh,

Chief, Professions and Intellectual Property Section, Health Care Task Force, Department of Justice, Antitrust Division, 600 East Street N.W., Room 3900, Washington, D.C. 20530.

Dear Ms. Kursh. This is in response to an article written in the Home Health Line regarding the proposed Department of Justice's final judgement for the United States versus Health Choice of Northwest Missouri Inc., et al, case number 956171–cv–sj–6.

As a home health provider, Total Professional Health Care has three major areas of concern. Although the prepared judgement appears to give the beneficiary the right to choose his or her provider, we fear that the method in which the alternatives are presented still favor the hospital based affiliated provider. Please refer to B#2, ''if the patient has no preference, a referring person shall indicate that Heartland has an excellent, fully accredited Ancillary Service that is available to the patient, and the appropriate Heartland brochure may be given.'' Based upon this reference, we would like to pose a question; If you were the beneficiary, who would you choose? The unknowing guest of the hospital could be swayed into believing that the hospital based affiliates are the ''only'' choice.

The second area of concern is the issue of quality care. Since it appears that there will a minimum amount of competitiveness among the ancillary services, who will ensure that the best care is provided? Can you ensure the beneficiary that his or her ''choice'' of providers is the correct one? Who is willing to take responsibility for inferior care should the situation arise?

Lastly, a member of the free standing provider community, our business will be dramatically affected by this proposed final judgement. We have already experienced difficulty accessing patient's charts. Several of the physicians who who have ordered our home health services for their patients in the past have yielded to internal pressures from within the hospitals to order hospital based home health agencies.

We have been providing quality care to our community since 1976 and have earned an excellent reputation. We consider the opportunities afforded to the hospital based ancillary services to be grossly unfair. We hope that you will consider these facts when making your final decision.

Thank you for allowing us to comment on this very important matter. Should you have any questions, please do not hesitate to contact me at (813) 531–0299.

Sincerely,

Margaret VanDeMar,

Regional Director.

cc: Susan Carmichael, President, NuMED Home Health Care

Idaho Home Health, Inc.

1910 Channing Way, Idaho Falls ID 83404, (208) 528–2877, (800) 464–2877, fax (208) 529–529–5867

December 3, 1995.

Gail Kursh,

Chief, Professions & Intellectual Property Section/Health Care Task Force, Department of Justice, Antitrust Division, 600 E St., N.W., Room 9300, Washington, D.C. 20530

Dear Ms. Kursh: The proposed settlement between the DOJ and Heartland Health System Inc., undermines the free enterprise system and sentences the small, community-based entrepreneur to the assembly line. A more equitable approach to the problem would be:

1. Strengthen limitations on the hospital's ability to refer its patients to its own hospital-based components;
2. Require the hospital to use a rotation system, which assures equitable referrals to all Providers in the area;
3. Require the hospital to permit (on their premises, during normal working hours) representatives of freestanding providers—other than their own hospital-based components—to visit their patients who have been admitted for hospitalization; and to expose the patient population to the availability of outside services as well;
4. Make the hospital publicly post its daily referrals to both its hospital-based entities and to other providers in the community.

Incorporating the above recommendations into the DOJ settlement would go a long way toward resolving the inequities that have existed between hospitals and community-based entities.

Thank you,

Frank Dalley,

President.

November 27, 1995

Gail Hursh,

Chief Professions & Intellectual Property Section, Health Care Task Force, Department of Justice, Antitrust Division, 600 E. Street, NW., Room 9300, Washington, D.C. 20530

Dear Ms. Kursh: I am an employee in a small, rural freestanding home health care agency. I have read with great dismay the recent DOJ ruling in the matter of United States v. Health Choice of Northwest Missouri Inc.

In our own community, a local hospital-based program has instituted unfair practices which have practically eliminated competition in our service area.

I know that in our government, numbers count. Let me add my voice to the many who

will ask you to modify the decision to include the following language:

• Strengthen limitations on a hospital's ability to refer its patients to its own hospital-based components;

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• Require the hospital to permit (on their premises, during normal working hours), representatives of freestanding providers;

• Make the hospital publicly post its daily referrals to both its hospital-based entities and to other providers in the community.

Sincerely yours.

Sharon Fries.

November 27, 1995

Gail Hursh,

Chief Professions & Intellectual Property Section, Health Care Task Force, Department of Justice, Antitrust Division, 600 E. Street, NW., Room 9300, Washington, D.C. 20530

Dear Ms. Kursh: I am an employee in a small, rural freestanding home health care agency. I have read with great dismay the recent DOJ ruling in the matter of United States v. Health Choice of Northwest Missouri Inc.

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Sincerely yours.

Lou Ann Balding.

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Sincerely yours,

Diane Gadomski

November 27, 1995.

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Sincerely yours,

Darrel Benneto

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Sincerely yours,

Jayne E. Majors

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Irma Powers

November 27, 1995.

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MaryAnn Perry

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Sincerely yours,

Sherri Rule

November 27, 1995.

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• FAIR competition requests in better, fair priced care for our patients.

Sincerely yours,

Joan Risk,

Gail Kursh,

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Emma Jean Fowler

November 27, 1995.

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Brenda Phillips

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Sincerely yours,

Stephanie Paderson,

November 27, 1995.

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Stephanie Wickstrom

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Donna Carlson Albire

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Sincerely yours,

Marybeth Coyne,

Occupational Therapist.

November 27, 1995.

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Sincerely,

Chris Renland

District Health Department No. 4

Alpena County, 1521 W. Chisholm St., Alpena, MI 49707, (517) 356–4507, Fax (517) 356–9080

November 29, 1995.

Gail Kursh,

Chief, Professional and Intellectual Property Section, Health Care Task Force, Department of Justice, Anti-Trust Division, 600 E Street, NW, Room 9300, Washington, DC 20530

Re: United States v. Health Choice of Northwest Missouri, Inc. et al., Case No. 95–6171–CV–SJ–6

Dear Ms. Kursh: It is with great concern that I read of the Department of Justice's proposed final judgement concerning the above case. As the proposed judgement currently reads, home health care programs which are not affiliated with hospitals are put at a severe disadvantage, because they will not have access to patients in a hospital's system.

The precedence this rule sets will not only be a blow to independent home health agencies, such as ours, but also to patients. At the time when patients are most in need of knowing their available options, they are least able to explore them. Safeguards must be in place to assure that patients are made aware of options available to them at the time of discharge. Only when knowing the options will a patient be able to make an informed choice.

Please let this letter serve as a request that the final judgement be modified to:

- Strengthen limitations on a hospital's ability to refer its patients to its own hospital based components;
- Require the hospital to use a rotation system which assures equitable referrals to all providers in the area; and
- Require the hospital to unbiasly inform a patient of his or her options when establishing their discharge plan.

Choice can only be choice when one knows what their alternatives are. Only by making such modifications will we ensure a patient's choice is protected.

Sincerely,

Christopher J. Benedict,

Health Educator.

District Health Department No. 4

Alpena County, 1521 W. Chisholm St., Alpena, MI 49707, (517) 356–4507, Fax (517) 356–9080

November 29, 1995.

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Sincerely,

Kathy Orban,

Home Care Nursing Director.

Harbors Home Health and Hospice

201 7th Street, Hoquiam, WA 98550, (360) 532–5454

December 1, 1995.

Gail Kursh,

Chief, Professional & Intellectual Property Section, Health Care Task Force, Department of Justice, Antitrust Division, 600 ''E'' Street, N.W., Room 9300, Washington, D.C. 20530

Re: Comments of proposed final judgement for United States vs. Health Choice of Northwest Missouri, Inc., et al., Case No. 95–6171–CV–SJ–6, U.S. District Court

I believe the policy as written does not adequately protect patient choice and fair competition.

I feel the hospital should be required to provide a quarterly updated list from the surveyors of Medicare and Medicaid certified providers to patients who were not receiving service from a Home Health Agency at time of hospital admission and do not have a preference of home care providers. Additionally, the referring entity should not be able to steer or influence patients toward their own provider entity. Hospitals should be prohibited from steering patients away from an established relationship with a free standing agency.

I have experienced in practice, patients who were open to a free standing agency on admission to the hospital and notice was given to the social service department of the established relationship. The patients were referred and opened to the facility based agency upon discharge. When queried, neither the patient or family made the choice to change and in some cases insisted they be referred back to their original agency so they might continue with the same caregivers. Other patients and families said they would stay with the hospital based to avoid bother and to be sure they could again be admitted to the facility. In other cases, the frail elderly suffered from confusion or just did what ''they'' recommended.

Frail elderly suffering from chronic illnesses deserve to be protected when their defenses are compromised.

Please see that the final judgement assures patient choice and fair competition protected by Medicare (42 USC § 1395a) and Medicaid (42 USC § 1396a(23).

Thank you for your consideration of these comments.

Sincerely,

DeLila Thorp,

Administrator.

Faith Community Hospital

171 Magnolia St., Jacksboro, Texas 76458, 817–567–6633, FAX 817–567–5714

November 27, 1995.

Gail Kursh,

Chief, Professions & Intellectual Property Section/Health Care Task Force, Dept. Of Justice, Antitrust Division, 600 E St., NW, Room 9300, Washington, DC 20530

I would like to take this opportunity to comment on the United States v. Health Choice of Northwest Missouri, Inc., et al., Case No. 95–6171–CV–SJ–6.

It is a fact that fraud is running ramped in home health and DME services in the health field. With the implementation of the Stark I and Stark II amendment, some of the fraud activity by hospitals and physicians has been curtailed.

I have no knowledge of case no. 95–6171–CV–SJ–6, however, I would like to respond to one of the provisions as set forth:

- If a physician orders an Ancillary Service and specifies the provider to be used (whether specifically written in the chart or other written notifications), then a referring person shall contact the patient indicating that the physician has ordered an Ancillary Service and has ordered that a particular

provider be used. The patient should be asked if this is acceptable, and if so, referred to that provider.

This section is where I have a problem due to the possibility that a physician who may have a vendetta against a hospital based home health service can willfully, without any repercussion, direct all patients away from that service.

The physician should not be allowed to order a patient to use a particular home health service. This should be solely the patients choice.

This judgement, if approved, can and probably will set a standard for other hospital systems. When you have only 2 or 3 physicians on medical staff and a physician becomes disgruntled with any faction of the hospital, dependent upon his client base, he could severely threaten the viability of the hospital.

So, with this in mind, I ask that you please reconsider the terminology used, whereby the physician can specify the provider.

Sincerely,

Ronald G. Ammons,

Administrator.

R.D. #3 Box 284, Meadville Pa. 16335

December 1, 1995.

Gail Kursh,

Chief, Professions & Intellectual Property Section/Health Care Task Force, Dept. of Justice, Antitrust Division, 600 E St., NW., Room 9300, Washington, DC 20530

Dear Gail Kursh: Regarding the article in Home Health Line, 11–13–1995, Vol. XX, No. 43, and the Dept. of Justice recommended home care referral policy for Heartland Hospital System Inc.

I am very concerned that Americans are losing their freedom of choice. I currently work for a home health company that is not locally hospital based. I have found citizens in our community, to a large extent, are unaware there is any choice and assume each company is one and the same. In the past I worked for the local hospital based program and when competition arrived positive changes occurred. I am aware of some changes that occurred prior to and since I left their employment. Competition has benefited our community. Example. Referred patients requiring home health care are now seen within 24°, unless the patient requests otherwise. Previously patients often were scheduled per office convenience with several day delays.

- Ordered therapy/treatment (which can safely be completed in the home) are more rapidly available (staff educated to complete) when the treatment is available from competition.
- Local low pay scale for home care nurses has been brought in line with surrounding communities.
- I realize that hospitals are concerned about their fiscal responsibility and home care is economically positive for the hospital but are there assurances that optimal care will be provided safely and efficiently to our society. I feel a monopoly may lead to a decline in services provided to the client/patient in home care. I agree with the ''Coalition for Quality Healthcare'' proposal . . . modifications are necessary to ensure optimal health care to our society. Freedom of choice should prevail. Patients and physicians will have freedom to change if dissatisfied with a current provider. I feel competition helps to ensure the best home care skilled services to our neighbors, friends, and loved ones.

Sincerely yours,

Sharon Ferguson

Memorial Medical Center of East Texas

P.O. Box 1447, Lufkin, Texas 75901 (409) 634–8111

November 29, 1995.

Gail Kursh,

Chief, Professions and Intellectual Property Section/Health Care Task Force, Department of Justice, Antitrust Division, 600 East Street, NW, Room 930, Washington, DC 20530

Dear Ms. Kursh, Memorial Medical Center of East Texas is a private, non-profit hospital system which also includes a skilled nursing facility, rehab facility, inpatient physiatric facility and home health care. In our community, population 40,000, there are eleven free-standing home health care agencies and two hospital based. The marketing efforts by the hospital based agencies are limited to access through the hospital medical staff system and educational programs for hospital staff such as social workers and utilization review nurses.

It poses an ethical dilemma for the hospital ''discharge planning'' staff members to give information or a list of other agencies for several reasons. We have no way to reliably ascertain the quality of care given by these agencies. Often we have patients who are admitted after being a patient of another home health agency and we have questions about the care that was rendered. For our hospital to give brochures or provide a list would constitute, in the eyes of the consumers, the endorsements of these agencies. This causes grave concern from the hospital risk management department. It would be impossible to keep a current list since agencies routinely open, close, change locations and change staff. To require the hospital to keep up with all of this is an unnecessary administrative burden.

In no other hospital practice are we required to advocate for our competition. If a patient comes in for outpatient lab or mammography we are not required to give them a listing of all other free-standing labs or mammography centers in our region. It has always been an enigma to me that the home health agencies were singled out for this constraint. Therefore, I wish to voice my support of the procedure developed by Heartland Health Systems and currently under consideration in the United States v. Health Choice of Northwest Missouri, Inc., et al., case no 95–6171–CV–SJ–6 currently in the United States District Courts for the Western District of Missouri.

Should you have any questions or need further input, I am available to you at 800–944–0825.

Thank you very much.

Patricia R. Jones,

Administrative Director, Memorial Medical Center HomeCare.

Supportive Care Services—Hospice Brazos Valley

2729 A East 29th Street, Bryan, TX 77802, Phone #: (409) 776–0793, 1–800–824–2326, Fax #: (409) 774–0041

November 29, 1995.

Gail Kursh,

Chief, Professions & Intellectual Property Section/Health Care Task Force, Department of Justice, Antitrust Division, 600 E St., NW, Room 9300, Washington, DC 20530

Dear Ms. Kursh: I am writing to you in response to a Texas Association for Home Care Fax Alert. This Alert was dated November 24, 1995. It was regarding the Dept. of Justice proposed final judgment for United States v. Health Choice of Northwest Missouri, Inc., et al.

My concerns emanate about the scenario of:

- If a physician orders an Ancillary Service, but does not specify the provider to use, then the patient shall be contacted and informed that his physician has ordered an Ancillary Service and shall be asked if he has a preference as to which provider to use.
- If the patient has no preference, a referring person shall indicate that Heartland has an excellent, fully accredited Ancillary Service that is available to the patient, and the appropriate Heartland brochure may be given. If the patient accepts, then the referral shall be made to Heartland's Ancillary Service.

It is this second paragraph that is of great concern to me as both a consumer and a provider. As a consumer, unless I have the advantage of full knowledge, how am I to have the ability to make an informed choice. By Heartland being allowed to present themselves without necessarily disclosing information regarding other possible Home Health or Hospice choices, my beliefs are there is a possibility of manipulation of consumer by Heartland or any other hospital with this advantage.

In Texas, TAHC Code of Ethics provisions appear to be more stringent than the proposed DOJ referral policy, thus protecting the consumer's right of informed choice. The point of significance is that the client must be provided information, regarding all options of home care service providers, not just hospital's (in which the client is receiving services) home care agency. For a client that had no previous knowledge about home care provider services, it would not be possible for him to make a fully informed decision of choice.

I greatly encourage to reconsider the DOJ's stance and final judgement for United States v. Health Choice of Northwest Missouri, Inc., et al. For the publics protection and to guarantee their right to full informed decision of choice, it would appear beneficial that the judgement follow the guideline of the TAHC Code of Ethics provisions regarding this situation.

If I may be of further assistance to you regarding this issue or if I may provide

further information, please do not hesitate to contact me. Thank you for your time and consideration.

Sincerely yours,

Timothy M. Brown

Gail Kursh,

Chief, Professions and Intellectual Property Section, Health Care Task Force, Dept. of Justice Antitrust Division, 600 E St., NW., Room 9300, Washington, DC 20530

To Whom It May Concern: This is in response to the Dept. of Justice proposed judgment for *United States* v. *Health Choice of Antitrust Missouri, Inc.* Case #95–6171–CV–SJ–6.

As a health care provider (RN) and consumer, it appalls me to know that hospitals may not be required to inform patients about alternatives in the health care market. Because a hospital informs a client of any available home health agencies does not mean the hospital endorses such agencies. Healthy competition is good for the consumer and serves as a check and balance system. Hospital based agencies would usually monopolize the market if this referral policy is permitted and quality care will be compromised.

Also, economically, competition allows the consumer to get the most service for their money. Please do not permit this to change.

Sincerely,

Barbara L. Lenecea

Marblehead Visiting Nurse Association, Inc.

Widger Road Medical Building, Marblehead, MA 01945–2146, Phone (617) 631–1900, FAX (617) 631–7944

November 20, 1995.

Ms. Gail Kursh,

Chief, Professions & Intellectual Property Section, Health Care Task Force, Dept. of Justice Antitrust Division, 600 E Street, NW., Room 9300, Washington, DC 20530

Dear Ms. Kursh: As the CEO of a visiting nurse agency which receives approximately 35% of its referrals from a hospital that has its own home health agency, I can truly speak to the referral policy issue.

At present, the patients being discharged from this hospital are frequently not only not given any choice for a provider of home health services he/she may require, but are refused the opportunity to utilize the services of an agency for whom they voice a preference.

Today, patients in need of care are allowed fewer and fewer choices. It is my belief that patients should not only be asked if they have a preference, but be given the opportunity to verbalize their choice of provider in their service area. Further, it seems logical for representatives of various home health agencies to be physically present in the hospitals, so that the home health plan of care may be established and followed up on in a timely fashion, thus making for a smoother transition for the patient and patient's family.

An equitable referral system is essential to ensure the patient has the freedom of choice and is given every opportunity to exercise his/her right of choice. This is one means by which the hospital may be held accountable for providing the patient's rights.

It is may hope and the hope of my staff, that the Department of Justice will consider these factors and support the Health Care Fairness Act of 1995 (H.R. 2400).

Sincerely,

Joyce L. Elliott

December 4, 1995.

Gail Kursh,

Chief, Professions & Intellectual Property, Section/Health Care Task Force, Dept. of Justice, Antitrust Division, 600 E St., NW., Room 9300, Washington, DC 20530.

Dear Mrs. Kursh: It greatly distresses me that there would be even slight consideration given to allowing hospital discharge planners the ability, by law, not to give patients choices available to them for home care.

Free standing agencies are not asking for recommendations from discharge planners in terms of the quality work we do. We feel that our work speaks for itself. We do however, expect for patients to be made aware that we exist.

This situation is the closest thing I have ever witnessed of the government actually participating in setting up a monopoly. What has happened to fair competition and patient choice?

Respectfully,

Susan Livvix

Memorial Hospital of Taylor County and Memorial Nursing Home

Eugene W. Arnett, President, Medford, Wisconsin 54451, Telephone: 715–748–8100, Fax: 715–748–8199

December 4, 1995.

Ms. Gail Kursh,

Chief, Professions & Intellectual Property Section/Health Care Task Force, Department of Justice—Antitrust Division, 600 E Street, NW., Room 9300, Washington, DC 20530.

Dear Ms. Kursh: I am in support of the Department of Justice recommended home health, DME, and hospice referral policy as outlined for Heartland Hospital in St. Joseph, Missouri.

Hospitals have internal mechanisms that provide for independent review or evaluation of the services offered. Offering names of other providers during discharge planning could infer the hospital is endorsing that agency.

I also support patient choice; but if the patient has no preference and asks the hospital for guidance, the hospital has an obligation to help that patient. Recommending their own services should not be misconstrued as a monopoly tactic.

Please consider these remarks when making a final judgment for United States.

Sincerely,

Carol A. Ahles,

Vice President—Administration.

Polyclinic Medical Center™

December 8, 1995.

Ms. Gail Kursh,

Chief, Professions & Intellectual Property Section/Health Care Task Force, Department of Justice, Antitrust Division, 600 E Street, NW., Room 93, Washington, D.C. 20530

Re: United States v. Health Choice of Northwest Missouri, Inc., et al., Case No. 95–6171–CV–SJ–6.

Dear Ms. Kursh: I am responding to the proposed settlement between the DOJ and Heartland Health System Inc., St. Joseph, Mo.

As the medical director for a large hospital-based home health care and hospice agency, I am very much in favor of the DOJ's recommended home health, DME and hospice referral policy for Heartland Hospital.

As we all know, patients are being sent home from hospitals ''quicker and sicker.'' Home health care and hospice care under the auspices of a hospital becomes the legal responsibility of the hospital. Our agencies are Medicare and Joint Commission certified. Quality of care and issues such a patient outcomes, patient satisfaction, etc. are studied by our hospital Quality Assessment Department, Administration, Professional Activities Committee on the Board of Directors, and the Board of Directors of the hospital. Hospital discharge planners are in an excellent position to know the qualifications of its own departments, but are not in a position to know the qualifications of other area providers.

The recommended policy is a good one and should become permanent.

Respectfully yours,

James F. Crispen,

Medical Director, Professional Home Health Care Agency & Professional Hospice Care (A Subsidiary of the Polyclinic Medical Center, Harrisburg, Pa).

Reavis Health Systems

1980 South Austin Avenue, Georgetown, TX 78626, (512)930–5877, Fax (512) 863–6506

December 1, 1995.

Ms. Gail Kursh,

Chief of Professions & Intellectual Property Section, Health Care Task Force, Department of Justice, Antitrust Division, 600 East Street NW #9300, Washington, DC 20530.

Dear Ms. Kursh: I want to applaud your judgment in the case of United States v. Health Choice of Northwest Missouri, Inc. I thoroughly believe it is imperative that the patient retain the utmost privilege and right of making the choice of a health care provider themselves. It is such a relief to finally have a precedent that sets that stage for higher ethical standards.

It has been my experience that when a health care facility is faced with stiff competition, patients rights are sometimes abused. I feel it is necessary for strict regulations in regard to Hospital-based health facilities and their disbursement of referrals. It is unfortunate the rights of individuals are most frequently abused in the interest of the larger institutions, and the patient so often is not even aware.

I want all patients to be provided with information notifying them they have a

choice in home health agencies. Hospitals should be required to provide the patient with a list of all prospective agencies. I would also like to see a provision that allows all home health agencies to leave educational materials. I do not feel this would make hospitals liable for the care rendered by the respective agencies.

It is time to stop the abuse and provide us all with equal and fair legislation.

Sincerely,

Nancy Reavis,

CEO, Reavis Health Systems, Inc.

MedCare Systems, Inc.

Grand Rapids 616.452.5700 • FAX 616.452.8822, Lansing 517.394.4435 • FAX 517.394.4439

December 6, 1995.

Ms. Gail Kursh,

Chief, Professional and Intellectual Property/ Section, Health Care Task Force, Dept. of Justice, Antitrust Division, 600 E. St., NW., Room 9300, Washington, D.C. 20530

Dear Ms. Kursh: I am writing in response to the article in Home Health Line of November 13, 1995. I am concerned as an administrator of a Medicare/Medicaid certified home care agency that the health care industry is not only being allowed but pushed to form mega-systems that violate antitrust values.

In the Grand Rapids area of Michigan where our corporate office is located, we have a hospital merger pending that will monopolize health care in this area, and effectually eliminate the balance of cost control and quality management that competition provides.

We are already seeing this in the home care industry. Because the hospitals have their own home care components, they direct the vast majority of discharges for home care to their own agencies. The protection of patient choice is not effective because the Medicare population is elderly and sometimes forgetful. They need *objective* support to make educated free choice. Even physicians who could educate their patients regarding special services through outside agencies are intimidated into using a hospital service that may not best meet the patient's needs.

The agency I work for has focused on developing services not previously available in the community. We hire critical care nurses for our cardiovascular program and provide in home telemetry. We have been told by many in the community that our services are the ones they would like to use but they cannot because their hospital administration directs them to use the hospital's program.

We need change, and control over provider driven referrals and care. Why are we putting the control in the financial hands of the biggest provider system in our country, the hospital, that has demonstrated for decades that it does not know how to control cost but instead shifts cost. Hospital based home care agencies are being used for cost shifting.

Small independent health care businesses need to be fostered in the managed care environment so that the true benefits of competition, cost control and quality, will be realized. We need to educate consumers and allow choice in health care.

Mega-monopoly providers who *direct* business to their own bottom line are not the answer.

We need to:

- Stop provide driven referral. We are shifting from physician provider driven to mega hospital provider driven.
- Require to rotate referrals for general med/surg cases. This will help educate the public and stimulate competition to the good of patients.
- Require hospitals to allow free standing home care agencies the freedom to visit their patients in the hospital.
- Require the hospital during the discharge planning process to provide patients a list of agencies that provide home care.
- Require mandatory education of hospital discharge planners regarding services available in the community that address specific, special patient needs.
- Allow the educated professional discharge planners to use their own professional, clinical judgement when counseling patients choosing an agency rather than direct to their hospital agency simply because they have been directed to do so.
- Prevent hospital administration from intimidating discharge planners or physicians into making self referrals to their own agency regardless of patient need. The doctor or discharge planner may know another agency that is better qualified to meet the specific patient's needs.
- Provide incentives for creative health care professionals to decrease cost while enhancing quality.

Sincerely,

Carol E. Veenstra

December 6, 1995.

Ms. Gail Kursh,

Chief, Professions & Intellectual Property Section/Health Care Task Force, Department of Justice, Antitrust Division, 600 E. St., Room 9300, Washington, DC 20530

Dear Ms. Kursh: I am writing in regards to the case United States v. Health Choice of Northwest Missouri, Inc. I am a MSW, LCSW Clinical Social Worker with 20 years experience in health care settings. I would like to comment on this case from the standpoint of patient self-determination, ie choice, and efficiency/cost effectiveness.

First, the proposed changes from the Coalition for Quality Healthcare are unreasonable and place undue burden on the discharge planner to ''take care of the vendor,'' not the patient. Documentation of referrals, daily posting of referrals, rotation system, etc is extra work which does not enhance the care of patients. Also, patient confidentiality precludes having vendor representatives roam the halls looking for clients.

Secondly, the Heartland approach which suggests that a patient should ask TWICE for the names of non-hospital affiliated vendors is disrespectful, time consuming, manipulative and an undue hardship in the patient.

Why can't reason dominate in this ruling? The hospital discharge planners can first discuss the hospital based home care program, then if the patient requests other vendor names/info, the discharge planner can share that info with the patient at that moment.

Obviously this case is between vendors and hospitals. Where is the patient in this and who is looking out for their needs/rights?

Thank you for the opportunity to express my comments.

Sincerely,

Brenda Wilson,

Lead Social Worker.

Central Hospice Care

1150 Hammond Drive, Suite B–2100, Atlanta, GA 30328, (770) 391–9531, Fax (770) 391–9732, (800) 581–8000

November 29, 1995.

Gail Kursh,

Chief, Professional & Intellectual Property Section/Health Care Task Force, Department of Justice, Antitrust Division, 600 E Street, N.W., Room 9300, Washington, D.C. 20530

Re: *Comments on Proposed Final Judgement: United States v. Health Choice of Northwest Missouri, Inc., et al., Case No. 95–6171–CV–SJ–6 in the U.S. District Court for the Western District Court for the Western District of Missouri*

Dear Ms. Kursh: As a Hospice provider I have first-hand knowledge of the subject matter the Department of Justice is dealing with in the above referenced matter. I also understand the influence a hospital can exert in a patient's selection of post-hospital ancillary services, including the selection of a hospice care provider. For these reasons I have reviewed and studied the DOJ's recommended home health, DME and hospice referral policy for Heartland Hospital.

In the interest of protecting patient choice (which is guaranteed by both Federal and State laws) as well as maintaining fair competition consistent with the antitrust laws and FTC regulations, I respectfully submit that the final proposed judgement (recommended policy) be modified as such:

—Strengthen limitations on the hospital's ability to refer its patients to its own hospital-based components;

—Require the hospital to provide patients with an updated list of Medicare/Medicaid providers in the community;

—Require the hospital to use a rotation system, which assures equitable referrals to all providers in the area;

—Require the hospital to permit (on their premises, during normal working hours) representatives of freestanding providers—other than their own hospital-based components—to visit their patients who have been admitted for hospitalization; and to expose the patient population to the availability of outside services as well;

—Make the hospital publicly post its daily referrals to both its hospital-based entities and to other providers in the community.

On behalf of our Hospice agency and the patients we serve, we respectfully ask that

you give these comments due consideration. These issues are of even more concern in today's era of health care and provider consolidation.

Sincerely,

Margot Marcus,

Manager, Central Hospice Care, 1150 Hammond Drive, Suite B–2100, Atlanta, GA 30328.

Heritage Home Health Inc.

December 4, 1995.

Gail Kursh,

Chief, Professions & Intellectual Property Section, Health Care Task Force, Department of Justice, Antitrust Division, 600 E. St. N.W., Room 9300, Washington, D.C. 20530

Re: United States v. Health Choice of Northwest Missouri, Inc. et al., Case No. 95–6171–CV–SJ–6

Dear Gail Kursh: After reading about the case of Heartland Health System Inc. in the Home Health System Line, we would like to respond to you with our concerns as we are in a very similar situation and we would like to request any information, decisions or assistance you can provide us.

We are Heritage Home Health Care, a proprietary freestanding Home Health Agency, and we have 5 branches. The agency is a small corporation owned and operated by myself and my mother.

We opened two branches eight months ago in counties that have a hospital based HHA and to date we have received *zero* referrals. In our other counties, we had received at least 80 to 100 from the hospital by this time. Montana is a CON state and it has established guidelines that allow two HHA in each county so there is the capability for choice. In the two counties with hospital based HHA, there are only two Home Health Agencies, ours and the Hospital based.

Enclosed is some of our correspondence in our efforts to try and promote patient choice or any kind of mechanism to minimize their weighting the individuals decision of a HHA. Presently the hospitals allow the hospital based HHA have an individual review the charts on a daily basis for any patient that would be in need of home health services. We are not allowed the same privilege because of patient confidentiality as our staff are not employees of the hospital. When the hospital Home Health personnel locates a possible referral, they call the Doctor and inform him that they can provide Home Health Services and get the physicians order.

Another concern is that the doctors depend on hospitals for many things, including the privilege of doing surgery, perhaps office space etc. Because a large amount of their revenue comes from their functions at the hospital, some doctors are not going to recommend any other home health agency if the hospital has one. If the doctors did recommend another home health agency, they could loose some of their privileges. The same goes for the patient. The patients will not go against the doctor's and/or hospital's wishes for fear of reprisal. This is especially true when there is only one doctor in town. That doctor could refuse to treat the patient and the patient would have to go out of town for treatment. This has actually happened in several instances.

Under the Conditions of Participation, at least in the Medicare program as I understand it, the patient must be given a choice in regards to their care giver.

As you can see by our attachments, the hospital not only doesn't give us referrals: it also tries to take the ones we have. We have also been told by people who have been in the hospital that Heritage was never mentioned to them. They were just informed that the hospital would be providing Home Health services when they went home or they stated the doctor has ordered Home Health and the hospital would be sending someone out.

Before we arrived, neither of the hospital agencies offered weekend care or 24 hour on call services. We offer this as part of our normal patient care. Also, we utilize LPNs for home health aids. Now due to competition, they have upgraded their service to include both of these. Without the competition factor, they would never have upgraded their services. If hospitals are permitted to monopolize the Home Health service the way they do now, there will not be any choice as no other home health agency will be able to survive.

In the counties where there are no Hospital based HHAs we have had no problems with them and each have their own mechanism for issuing referrals. The hospitals refer in any of the following manners:

1. Allows the review of the admissions sheets daily.
2. Has a rotation basis if the person does not have a preference after given a choice.
3. If an agency had previously provided services, they will call that agency first or ask the individual if they would like to continue with the agency they had previously used.
4. The discharge planner makes a notation in the medical chart to the doctor such as would you like to order home health.
5. Schedule discharge planning meetings held with ancillary service providers.

Brochures of ancillary services are given to the patient. One of the hospital's provides these brochures in their packet that is given to every one that is admitted.

Is there some sort of mechanism, that could provide statistical data to show how many Home Health referrals are made and to what agency? If there is not, there should be and it should also be public information.

We are a Medicare Certified and State Licensed agency which all home health agencies must be to provide Medicare services. In the last two surveys, we did not have any deficiencies so not only do we meet the required guidelines, but this verifies that we provide quality care.

This is only a small sampling of some of the problems that are occurring. If a judgement is in favor of the hospital based agencies, it would only compound problems for existing Home Health Agencies. Your decision will have a very large impact on the hospital referral processes in the future. I would like very much to converse with you on this subject. Please call me at (406) 443–2186.

Sincerely,

Matthew F. Komac,

Administrator.

Metro Home Health Care Services, Inc.

3200 Greenfield Road, Suite 260, Dearborn, Michigan 48120, Telephone: (313) 336–6303, FAX: (313) 336–7157

November 21, 1995.

Ms. Gail Kursh,

Chief, Professions & Intellectual Property Section/Health Care Task Force, Department of Justice, Antitrust Division, 600 E Street, NW., Room 9300, Washington, DC 20530.

Dear Ms. Kursh: Hospitals have cost the Medicare program hundreds of millions of dollars by shifting hospital costs down into their Medicare home health agencies (HHA). These agencies are paid cost, allowing the hospital to profit from shifting expenses to its home care agency.

This encourages the hospital to increase referrals to its HHA because the bigger its hospital based HHA, the more of the hospital's costs are paid for under the Medicare home health agency benefit. The attached will show that and the American Hospital Association advocates its hospitals to maximize Medicare reimbursement this way.

Should the Department of Justice encourage hospitals to make profits off Medicare referrals?

Sincerely,

Richard A. Porter,

President/Administrator.

Numerous Enclosures

St. Francis Hospital

2016 South Main Street, Maryville, MO 64468, Phone: (816) 562–2600, Fax: (816) 562–2411

December 26, 1995.

Mr. Edward D. Eliasberg, Jr.

Professions in Intellectual Property, Bicentennial Building, Room 9422, 600 E. Street NW, Washington, DC 20530

Dear Mr. Eliasberg: I'm writing this letter relative to the allegations filed against Heartland Health System in St. Joseph, Missouri. There is a group of citizens in the St. Joseph area who refer to their coalition as the Coalition for Quality Health Care. As a part of their information campaign, they are telling people that Heartland Hospital owns rural hospitals in Northwest Missouri, including St. Francis Hospital in Maryville. I'm writing this letter to set the record straight that St. Francis Hospital, Maryville, Missouri, is an independent, not-for-profit corporation whose sole member is SSM Health Care System of St. Louis, Missouri. The sponsoring organization of SSM Health Care System is the Franciscan Sisters of Mary of St. Louis, Missouri. Please understand that St. Francis Hospital is *not* owned, operated, managed, or controlled by Heartland Health System.

If you have any questions in this regard, then please contact me.

Sincerely,

Ray Brazier,

President.

To Whom It May Concern: Enclosed are some clippings from the St. Joseph, Missouri newspaper. Perhaps you have already received copies of them, but if not, please read them.

It would be well if some were to come investigate the situation in St. Joseph. I am sure you know a lot about what is going on, but probably there is much you don't know.

What we really need is a hospital that will be in competition with Heartland West. When an individual has surgery, they only keep them for one, two, or three days, regardless of how serious it might be. They are very short of rooms at Heartland East and people often are sent home and called when a room is available. This is ridiculous since Heartland West is setting down there with lots of vacancies. They have spent Millions of dollars to add on at Heartland East but none of the building has helped the room situation. They are trying to get a monopoly on all the doctors in town, but some are not joining them.

Heartland West is to be turned into a center for long term care—mostly older people. On the 5th floor of this institution is a Mental Health area which supposedly is locked at all times. But some of those people could find a way to get off the floor and it would be very dangerous for the older people who might be living there. They closed the emergency room which was convenient to people who do not have cars, etc. and everyone has to go to Heartland East, waiting several hours before being taken care of.

I do not wish to sign this letter, but I do feel the government should step in and straighten things out. They are short of nurses and admittance help and when someone quits they do not replace them. Those going in on emergency or accident have to be taken in the front door of the hospital where every one can see them. 2 young girls were taken there with serious injuries following a car accident. They had to spend the night in the surgery room until rooms were available for them in ICU.

This is just a little about the ways things are and I thought I could add it to your investigation.

Shepherd's Services, Inc.

12970 Pandora Drive, Suite 200, Dallas, TX 75238, (214) 340–3193, (214) 340–3195 Fax

November 29, 1995.

Gail Kursh,

Chief, Professions & Intellectual Property Section, Health Care Task Force, Department of Justice, Antitrust Division, 600 E. St. NW., Room 9300, Washington, DC 20530

Re: United States v. Health Choice of Northwest Missouri, Inc. et al., Case No. 95–6171–CV–SJ–6, District Court for the Western District of Missouri

Dear Ms. Kursh: We would like to comment on the proposed final judgment in the above case:

Since we do not have the full pleading, we are not completely aware of the full scope of this litigation. We are aware, however, of the portion that would effect our home health care agency, and—indeed—the entire home health care industry. We are most concerned about those who are covered by Medicare and Medicaid, or by personal pay. Since HMOs have already restricted the patient's choices by their system of operation, this essential removes options from the hospital as well.

1. We think the system proposed by Heartland Health System, is extremely prejudicial to other home health providers in the community. Since the legislation enabling Medicare and Medicaid is founded on a basic principle that patients have true freedom on choice—and mandates such—any action by a health care provider that intimidates the patient in any way, either overtly or covertly, is contravening the intention of the law.

a. In the initial contact, the hospital is, in essence, questioning the physician's competence in his ability to name a provider. Since the same Patient's Rights extend to the physician, it would be hoped—but often unfulfilled—that the physician or his staff would have educated the patient about freedom of choice.

b. The proposed resolution, written with an extreme bias in favor of Heartland Health System, virtually guarantees no referrals in all but the most exceptional cases. The patient is not advised of his rights under Medicare or Medicaid, but only asked if there is a preferred provider. Since many, if not most, of the patients we have on service were unaware of their rights before they were explained to them, simply asking if a provider is preferred is going to elicit, in most cases, an uneducated answer, not an informed one.

Example:

1. An elderly patient was admitted from our service to a local hospital. The discharge planner of the hospital was told of the patient's relationship to our agency. Upon discharge the patient was advised, while still very disoriented, that home care had been ordered. The planner asked if the patient had a preference. Upon being asked, the patient could remember our Director of Nurse's name and the aide's name, but not our agency name. The planner discharged the patient to the hospital's agency without any attempt to help the patient find us. Our brochure was on the table but was out of sight of the patient. Our name was in the patient's chart. Rather than assisting the patient, the planner simply said they would take care of it. When the agency showed up for a visit, the patient called us to see if we could send the previous nurse and aide were available since they had been so wonderful to her. Finding out what had happened, we asked the agency to transfer the patient. They refused. Following up, we advised the patient of the Medicare rights and the choice of provider clause. The patient, ''didn't want to make the hospital angry'' and did not change.

c. In the second phase of the proposed process, Heartland can give the patient a full sales pitch, again with no reference to patient rights, and not mention other possible options. Only a very assertive patient would object and ask about other options. Again, the reasons are many, but ignorance of the system is very high on the list. Since Medicare will not reimburse advertising, the major hospitals, with huge financial reserves from other income sources, have done widespread public relations campaigns. Therefore, they have name recognition with the patients. After all, they are often in a hospital with the same, or similar name. Name recognition and credentials do not necessarily equate with providing quality care, as so many of those covered by HMOs have found to their dismay. In Texas the law prohibits an agency from having to be Joint Commission certified since Medicare certification is equivalent.

Again, in this phase, the patient who would be assertive enough to want additional information to make an informed, intelligent decision, is essentially left to his or her own devices by the abstract referral to the telephone book. No attempt is made to provide the patient reasonable service. If the patient asks for assistance a second time, the planner gives verbal choices. It is widely recognized that, in terms of mental retention verbal presentation which is the least preferred method of communication.

Point of information:

The discharge planner was a disinterested party in terms of who provided the proposed care, and was primarily a patient advocate. For many years, hospitals used one of two methods for making referrals:

1. A rotation between agencies that had signed up with the hospital, or:

2. Agencies provided the hospital information about their services that could be distributed to the patients.

A suitably austere planner could, again, intimidate the patient with lack of assistance and this barrage of noninformation.

Example:

1. A patient who chose our service before admission to a local hospital: Although the patient was committed to service with us, the discharge planner, who was actually an employee of the hospital's home health care agency, refused to discharge the patient to us. Earlier in the afternoon the same social worker had informed us that the patient was not going to be released until the next day. That afternoon the patient was abruptly discharged to the hospital agency. When the patient objected he was told, in essence, the hospital did not know us. If our administrator had not happened to have stopped by while the patient was being transferred to a wheel chair for discharge, he would have been at home under the hospital's service in spite of his objections. This was a very assertive client. You can imagine how much courage it would have taken for someone who was frail and elderly to offer this much resistance.

Note also the language in the proposed final judgment. ''* * * the referring person cannot make a recommendation. * * *'' This is an extremely restrictive phrase for a legal judgment. A planner will be in violation of the judgment if any other phraseology is used.

2. In clinical professions engaged in such practices as counseling—including social workers covered by their own code of ethics—a client is to be offered three choices

during a referral, and is informed how to make an informed choice about other options. In relationships between home health care, and related services, and hospitals this ethical courtesy not followed. The Texas Association for Home Care (TAHC), of which our agency is a member, is extremely concerned about ethical practices in this area, and recently unanimously passed a Code of Ethics. The Code covers both free standing and hospital based agencies who are members of TAHC. Two points are essential to our cooperative efforts to provide the highest quality of care to our clients:

a. Agencies shall honestly and conscientiously cooperate in providing information about referrals and shall work together to assure comprehensive services to their clients and their families.

b. Member agencies shall not engage in coercive or unreasonably restrictive exclusionary behavior which would restrict or impede consumer choice of provider agencies. A member agency or related entity that provides a screen to clients for home care referrals shall not use that position to influence a client's choice to direct referrals to itself, and shall inform clients of the availability of home care providers and advise clients that they have the right to choose the provider they prefer.

Other Observations

1. Following these guidelines would not be excessively restrictive on hospitals. They would allow them access to the patients on an equal footing with other providers. The very fact that the planner is an employee of the hospital places that person in a ''position of influence'' that is hardly negligible in terms of eliciting preferential responses.

2. In a metropolitan area it is unreasonable to expect the discharge planner to be acquainted with every available agency, nor to serve as a spokesperson for other agencies. The disclaimer, (''no independent review * * *'' etc.) is appropriate. As we receive requests for information we attempt to educate the prospective patient. It is reasonable to give basic guidelines on how to select providers of any ancillary services. Again, the goal would be to provide equal footing as outlined in the TAHC Code of Ethics. It is not unreasonable to ask the hospital to provide basic patient rights information to their patients. We utilize several different suppliers of DME equipment. Where a major appliance, for example a particular bed required for the patient's care, we advise them of other options that are available to them.

Point of information:

In most cases the patient truly has no preference and follows our recommendation because they trust us.

Recognizing this ''position of influence,'' the hospital will have many patients who do not have a preference. There will be plenty of opportunity for them to admit those patients without prejudicing opportunities for other providers.

Recommendations

We believe the following guidelines are patient oriented and equitable for all providers.

1. If a physician orders a specific provider that order should be honored. An order for Ancillary Services is as binding as any other medical order. A nurse does not ask the patient if medical orders are acceptable.

2. If the patient does not express a preference, the patient should be educated about how to make an informed decision rather than summarily making decisions for them.

3. In recommending their own agency, discharge planners should provide available information on other providers. As a minimum the planner should provide the applicable section of the classified section of the telephone book in which alternative providers are listed.

4. If brochures are provided from the hospital agency, brochures from other agencies should also be provided to help the patient in making an informed decision.

Thank you for your time in reviewing and considering our comments and recommendations.

Sincerely,

Richard G. Copeland,

Administrator.

January 18, 1996.

Gail Kursch.

Chief, Professions and Intellectual Property Section, Health Care Task Force, Department of Justice, Antitrust Division, 600 East Street NW., Room 9300, Washington, DC 20530.

Dear Ms. Kursh: I am writing in support of the DOJ's proposed final judgment for United States vs. Health Choice of Northwest Missouri, Inc., Case Number 95–6171–CV–SJ–6.

As a home health care professional, I am very concerned about the protection of patient choice and the quality of health care all patients receive.

The only home care agency of which a hospital can speak with authority and assurance is its own. Recommending other agencies is a liability issue. There is no way hospital administration and discharge planners can be sure of the quality of services provided by other agencies.

If a patient has a request for an agency, other than that recommended by his physician, he simply needs to indicate that preference to the appropriate party. If the patient is interested in other providers, referring them to the yellow pages provides an organized and unbiased information source.

Thank you for the opportunity to voice my opinion.

Respectfully,

Anne Santora

Ramadan Hand Institute, Lake Butler Hospital

850 E. Main Street, Lake Butler, FL 32054, (904) 496–2323

January 19, 1996.

Gail Kursh,

Chief, Professions and Intellectual Property Section, Health Care Task Force, Department of Justice, Antitrust Division, 600 East Street NW., Room 9300, Washington, DC 20530

Dear Ms. Kursh: I am writing in support of the DOJ's proposed final judgment for United States vs. Health Choice of Northwest Missouri, Inc., Case Number 95–6171–CV–SJ–6.

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Thank you for the opportunity to voice my opinion.

Respectfully,

Pamela B. Howard,

Hospital Administrator.

January 18, 1996.

Gail Kursch,

Chief, Professions and Intellectual Property Section, Health Care Task Force, Department of Justice, Antitrust Division, 600 East Street NW., Room 9300, Washington, DC 20530

Dear Ms. Kursh: I am writing in support of the DOJ's proposed final judgment for United States vs. Health Choice of Northwest Missouri, Inc., Case Number 95–6171–CV–SJ–6.

As a home health care professional. I am very concerned about the protection of patient choice and the quality of health care all patients receive.

The only home care agency of which a hospital can speak with authority and assurance is its own. Recommending other agencies is a liability issue. There is no way hospital administration and discharge planners can be sure of the quality of services provided by other agencies.

If a patient has a request for an agency, other than that recommended by his physician, he simply needs to indicate that preference to the appropriate party. If the patient is interested in other providers, referring them to the yellow pages provides an organized and unbiased information source.

Thank you for the opportunity to voice my opinion.

Respectfully,

Patti Hecht

January 18, 1996.

Gail Kursh,

Chief, Professions and Intellectual Property Section, Health Care Task Force, Department of Justice, Antitrust Division, 600 East Street N.W., Room 9300, Washington, D.C. 20530.

Dear Ms. Kursh: I am writing in support of the DOJ's proposed final judgment for United

States vs. Health Choice of Northwest Missouri, Inc., Case Number 95–6171–CV–SJ–6.

As a home health care professional, I am very concerned about the protection of patient choice and the quality of health care all patients receive.

The only home care agency of which a hospital can speak with authority and assurance is its own. Recommending other agencies is a liability issue. There is no way hospital administration and discharge planners can be sure of the quality of services provided by other agencies.

If a patient has a request for an agency, other than that recommended by his physician, he simply needs to indicate that preference to the appropriate party. If the patient is interested in other providers, referring them to the yellow pages provides an organized and unbiased information source.

Thank you for the opportunity to voice my opinion.

Respectfully,

Ann Reilly

Athens-Limestone Hospital

700 West Market Street, P.O. Box 999, Athens, Alabama 35611, Phone (205) 233–9292.

January 19, 1996.

Ms. Gail Kursh,

Chief, Professions and Intellectual Property Section, Health Care Task Force, Department of Justice, Antitrust Division, 600 East Street N.W., Room 9300, Washington, D.C. 20530.

Dear Ms. Kursh: I am writing in support of the DOJ's proposed final judgment for United States vs. Health Choice of Northwest Missouri, Inc., Case Number 95–6171–CV–SJ–6.

As a home health care professional, I am very concerned about the protection of patient choice and the quality of health care all patients receive.

The only home care agency of which a hospital can speak with authority and assurance is its own. Recommending other agencies is a liability issue. There is no way hospital administration and discharge planners can be sure of the quality of services provided by other agencies.

If a patient has a request for an agency, other than that recommended by his physician, he simply needs to indicate that preference to the appropriate party. If the patient is interested in other providers, referring them to the yellow pages provides an organized and unbiased information source.

Thank you for the opportunity to voice my opinion.

Respectfully,

Philip E. Dotson,

Chief Executive Officer.

Mississippi Baptist Medical Center

January 29, 1996.

Gail Kursh,

Chief, Professions and Intellectual Property Section, Health Care Task Force, Department of Justice, 600 East Street NW., Room 9300, Washington, DC 20530.

Dear Ms. Kursh: I am writing in support of the DOJ's proposed final judgment for United States vs. Health Choice of Northwest Missouri, Inc., Case Number 95–6171–CV–SJ–6.

As a home health care professional, I am very concerned about the protection of patient choice and the quality of health care all patients receive. Also, as a member of NAHC, I am disappointed in its opposition to this DOJ ruling.

The only home care agency of which a hospital can speak with authority and assurance is its own. Recommending other agencies is a liability issue. There is no way hospital administration and discharge planners can be sure of the quality of services provided by other agencies.

If a patient has a request for an agency, other than that recommended by his physician, he simply needs to indicate that preference to the appropriate party. If the patient is interested in other providers, referred them to the yellow pages provides an organized and unbiased information source.

Thank you for the opportunity to voice my opinion.

Respectfully,

Dan Gore,

Asst. Exec. Dir., Mississippi Baptist Medical Center, Central Mississippi Health Care at Home.

St. Joseph Convalescent Center

811 North 9th Street, St. Joseph, MO 64501, Phone: (816) 233–5164.

February 5, 1996.

Edward D. Eliasberg, Jr.,

U.S. Department of Justice, Antitrust Division, Bicentennial Building, 600 E Street NW., Washington, DC 20530.

Re: U.S. v. Health Choice of Northwest Missouri, Inc.

Dear Mr. Edward D. Eliasberg, Jr. I am returning my letter for your record so that you may submit it. If you need any more information I would be happy to cooperate in this matter.

Thank you.

Lisa Smith

U.S. Department of Justice

Antitrust Division, Bicentennial Building, 600 E Street, NW, Washington, DC 20530

January 18, 1996.

Ms. Lisa Smith

St. Joseph Convalescent Center, P.O. Box 283, 881 North 9th Street, St. Joseph, MO 64502

Re: *U.S. v. Health Choice of Northwest Missouri, Inc.*

Dear. Ms. Smith: This is in regard to the enclosed October 4, 1995 letter from you to Gail Kursh. You apparently sent us the letter in order to comment upon the proposed Final Judgment in *United States v. Health Choice of Northwest Missouri, Inc. el al.* You request that the letter be kept confidential.

We are returning your letter because the federal statute that governs the entrance of proposed final judgments in federal government civil antitrust cases, 15 U.S.C. § 16(b)–(h), requires us to publish and file with the Court all comments received. We were not sure you were aware of this provision.

You are, of course, free to resubmit the letter to us if you have no objection to your identity being disclosed. You also can, if you like, submit a redacted or anonymous letter or do nothing at all.

We are trying to finish our statutorily-required response to the comments as expeditiously as possible. We therefore request that you promptly send us any comment you care to submit or resubmit.

Sincerely yours,

Edward D. Eliasberg, Jr.,

Attorney.

Enclosure

October 4, 1995.

Gail Kursh,

Chief, Professions and Intellectual Property Section, Health Care Task Force, Department of Justice, Antitrust Division, 600 E Street, N.W. Room 9300, Washington, D.C. 20530

Dear Ms. Kursh: We need help now. I have been in this industry since 1984 and have never experienced such shortage of patients for such a long period of time. The trend right now is if you send a resident to the hospital for any reason they are treated and then sent to the skilled unit or acute unit at Heartland West. They are kept for as many days as medicare allows. When we call the social service to check on our patients we are given the run around. Some patients are tentatively placed in another facility that was owned by Heartland, until we called the floor to check on our resident and found out what was going on. They were going to place a dialysis patient with history of noncompliance with diet and fluids and fluctuating blood sugars to a residential care facility. They do not allow us to be a part of the care plan process during their stay. When you try to contact Social Service they no longer have anyone to answer the phone so you must leave a message and they seldom return your call. When they do return your call they either do not know what is going on or they are uncooperative. When you call the resident's physician to check on the patient they do not know what is going on with the resident—they do not make discharge plans the paid Heartland staff and Heartland doctors make these decisions. Today for instance, one of our residents who had been hospitalized recently was to return at 12:30 p.m. At 2:15 p.m. today she had still not returned. We tried to find out what was going on through social service and the floor—they had no idea what was going on—so we went and picked up the resident. We have been told that the resident is asked to sign a paper stating they want to go to Heartland nursing home if they need nursing home care. These elderly patients are not given a choice as to placement outside of Heartland. We talked to the head of social service at Heartland and he didn't even know

what we offered. We have been informed that if social service does try to place outside of Heartland they are reprimanded for this practice. In less they have a group of independent social workers or a group of people to evaluate what they are doing with these elderly people this practice will not change. I have tried to involve many groups at different times and no one wants to help when it comes to Heartland. Heartland owns this town and no one will stand up to them. What they are doing is wrong—the monopoly is wrong. The money that medicare and medicaid pays them is unbelievable. Heartland's nursing home should get the same reimbursement and inspectors with the same rules and regulations that we have to follow. All Heartland West is a very large nursing home. A couple of years ago when we were hearing the rumors about them starting there nursing facility, they had meetings with the nursing home industry denying these rumors. They promised to have meetings with us on quarterly basis to keep us informed of what was going on but there was no plans for a nursing home. That was the last meeting that they ever had. I can not imagine the government allowing something so unfair going on. They say nursing homes cost the government so much money but we can not cost nearly as much as these type of setups. I hope someone can help us. Everyone in health care has felt a large impact due to Heartland Systems. When we talk to people they do not get information about any outside nursing homes. We have taken brochures to Heartland but I feel they are probably never circulated. We used to average 4 or 5 residents admitted from Heartland each month since January 1995. July 26, 1995 was the last new resident that we received from Heartland. On August 23, 1995 we received a new resident who expired within a few days. These are the type of patients we get now hard to take care of, very ill or the patients you can rehab to go home. We have gotten one call on a new resident but she ended up going to skilled because she still had medicare days to use. They make no bones about what they are doing. We call them to check on them on skilled ward and they say they have only been there for a few days and their time is not up they will contact me when it is. They are bleeding medicare and medicaid for all they can. When we tell the social workers what we offer they act like this is the first time they have ever heard of us. They are building a residential facility out by the new hospital also. How can this be possible? They don't need a certificate of need. They are trying to buy other nursing homes in town also. Please try to do something for us.

There are a lot of good nursing homes in this town but how long can we all survive without patients, not very long. This is so unfair and we feel that no one can hear our cries. I have even made trips to the hospital trying to get patients but these fall on deaf ears also. Between the hospital and home health they pretty much control the elderly population in this town and are fully aware of this. Help us know before it is to late. I hope this is kept in the highest confidence for we are struggling now to get patients and if they knew what we are telling you they would really give us a hard time. Thank you for your time.

Sincerely,

Lisa Smith

Raulerson Hospital

January 30, 1996.

Gail Kursh,

Chief, Professions and Intellectual Property Section, Health Care Task Force, Department of Justice, Antitrust Division, 600 East Street N.W., Room 9300, Washington DC 20530

Dear Ms. Kursh: I am writing in support of the DOJ's proposed final judgment for United States vs, Health Choice of Northwest Missouri, Inc., Case Number 95–6171–CV–SJ–6.

As a home health care professional, I am very concerned about the protection of patient choice and the quality of health care all patients receive.

The only home care agency of which a hospital can speak with authority and assurance is its own. Recommending other agencies is a liability issue. There is no way hospital administration and discharge planners can be sure of the quality of services provided by other agencies.

If a patient has a request for an agency, other than that recommended by his physician, he simply needs to indicate their preference to the appropriate party. If the patient is interested in other providers, referring them to the yellow pages provides an organized and unbiased information source.

Thank you for the opportunity to voice my opinion.

Respectfully,

Frank Irby,

Chief Executive Officer.

Raulerson Home Care

217 S.W. Park Street, Okeechobee, Florida 34974, (941) 357–0080, (800) 440–2227, Fax (941) 357–1081

January 30, 1996.

Gail Kursh,

Chief, Professions and Intellectual Property Section, Health Care Task Force, Department of Justice, Antitrust Division, 600 East Street N.W., Room 9300, Washington DC 20530

Dear Ms. Kursh: I am writing in support of the DOJ's proposed final judgment for United States vs, Health Choice of Northwest Missouri, Inc., Case Number 95–6171–CV–SJ–6.

As a home health care professional, I am very concerned about the protection of patient choice and the quality of health care all patients receive.

The only home care agency of which a hospital can speak with authority and assurance is its own. Recommending other agencies is a liability issue. There is no way hospital administration and discharge planners can be sure of the quality of services provided by other agencies.

If a patient has a request for an agency, other than that recommended by his physician, he simply needs to indicate their preference to the appropriate party. If the patient is interested in other providers, referring them to the yellow pages provides an organized and unbiased information source.

Thank you for the opportunity to voice my opinion.

Respectfully,

Lisa G. Smith,

Home Health Administrator.

Missouri Alliance for Home Care

431 E. McCarty Street, Jefferson City, MO 65101–3103, 573–6342, Fax 573–6343

February 28, 1996.

Honorable Howard Sachs,

U.S. District Court, Western District, Western Division, U.S. Court House, 811 Grand Ave., Kansas City, MO 64106

Re: Proposed Final Judgment: United States v. Health Choice of Northwest Missouri, Inc., et al., Civil No. 95–6171–CV–SJ–6 (W.D.Mo.)

Dear Judge Sachs: The Missouri Alliance for Home Care (MAHC) is responding to the above captioned case concerning the provision of ancillary services that is attached to the Final Consent Judgment against Heartland Health System, Inc.

MAHC is the home care industry trade association in Missouri. Membership includes companies that provide home health, hospice, home infusion therapy, in-home long term care services and home medical equipment. The membership of MAHC is broad-based representing hospital based, as well as, private freestanding companies.

MAHC feels that the final judgment fails in several important areas:

1. It does not meet the letter of the law establishing criteria for fair competition as intended by Medicare and Medicaid.

2. It helps create a monopoly in an area well served by competitive providers.

3. It does not consider patients without adequate health coverage allowing for cherry picking of patients with financial resources.

4. It treats patients as a commodity to be controlled, directed, indeed steered to ancillary services.

5. This decision has national ramifications and should be widely disseminated. A national understanding of this new referral policy and its impact on consumers and providers is crucial. The critical nature of these ramifications further impresses the need to ensure this policy complies with the rules set forth under the Medicare Act, something the Heartland policy does not do.

MAHC feels the patient should be empowered to make decisions. They should be informed of the process of arranging for home care services, what alternative providers are available and the financial costs to them depending upon their decision.

At a time when the patient is at their most vulnerable they turn to the physician and hospital to give them and their families help in selecting services to ease the transition to home. Many of these patients may not realize that they have a choice. If hospital personnel or their physician steers their care to hospital based services the patient will probably accept, without question, that referral, thus preventing them the option to exercise their

right to choose. The very act of forcing a patient to ask twice for alternative providers is demeaning to them. We should be servicing the sick by assisting them to a comfortable transition home not manipulating them.

MAHC favors several changes to the judgment:

1. *Patients should be informed and given the power to make a choice.* Patients should be given a patients Bill of Rights to educate themselves. They should understand what choices they will need to make, how to go about making those choices and any limitations of their insurance coverage or payor for those services. If the patient previously had a provider that they wish to continue using that choice should be allowed.

2. *Patients should be given information about alternative providers.* The hospital discharge process should provide each patient requiring any home care service with a list of companies that can provide the services to meet the patient's needs. The hospital should be required to maintain and make available an up-to-date listing of qualified providers. The hospital ancillary services should be on the list in alphabetical order. The patient should be assured that selection of any company other than the hospitals' affiliate will not affect their care at the hospital or prevent them from receiving future care from the hospital. This list should contain basic information about services available from each provider including how the patient contacts the company and it should be updated quarterly.

3. *The patient's discharge information should be shared.* As the patient discusses options with the competing companies, appropriate discharge information about their medical care and needed services in the home should be shared with the agency the patient selects. All companies should discuss how services will be provided and what costs, if any, the patient will be expected to pay.

4. *Patients have the right to be aware of any financial relationships or incentives between the person making a referral and the provider.* If the patient and the patient's family have no preference, and no desire for written information, then the patient's physician should make the choice of a home care provider. There should be no pressure or incentive on the physician or any of the hospital medical staff to refer patients to the hospital's affiliated services. If there is a financial relationship between the provider and the physician, including but not limited to the physician being an employee of or having a financial interest in the hospital, or the physician's practice being owned by the hospital, this must be disclosed to the patient. Patients have a right to know if the physician or hospital has a financial interest in the provider or company where they are referred.

This Final Judgment sends a confusing message from the government. Decisions in the past have sought to lower health care costs, indeed, the government has supported competition as a way to decrease costs. Past policy and current Medicare law encourages patient freedom of choice of providers. Legal action by the Department of Justice has been taken in the past to prevent referrals by health care decision makers that have a financial interest in provider companies.

The Final Judgment seems to refute all of these past decisions. Government policy needs to give consistent direction. MAHC encourages you to reconsider your decision regarding the referral policy and to instead insist on a national policy which protects the patient's right to choose and promotes fair market competition among providers.

Sincerely,

Dale E. Smith,

President, Missouri Alliance for Home Care.

cc: Gail Kursh, Esq., Chief Professional & Intellectual Property Section, Health Care Task Force, Department of Justice

Jay Nixon, Attorney General of Missouri

[FR Doc. 96–13754 Filed 6–11–96; 8:45 am]

BILLING CODE 4410–01–M