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The Heller School for Social Policy and Management

## Health Care Cost Management in Massachusetts: A Discussion of Options

### Meeting #7: State Regulatory Strategies

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### Conference Report

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# State Regulatory Strategies

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## Summary

The principal areas of state regulation to control health care spending have historically been controlling capital health care investment through certificate of need (CON) programs and hospital rate-setting. State CON programs were widespread in the 1970s following federal legislation requiring their use. Many of these programs had shortcomings that limited their effectiveness, including vague definitions of need, limited coverage of health care facilities and services, and inability to hold applicants accountable following CON approval. The CON process was highly political and frequently supported by incumbents as a barrier to entry. Empirical analysis indicates that state CON programs did not usually control spending.

State hospital rate-setting programs came into favor in the 1970s at a time when hospitals were reimbursed primarily based on costs. State rate-setting programs were highly complex and very political. Early studies of rate-setting programs showed a positive impact on spending trends, however, studies in later years showed little effect. By the 1990s, managed care, increased hospital competition, and Medicare prospective payment all combined to reduce hospital spending, and state rate-setting provided little incremental benefit.

The design of state CON programs and hospital rate-setting programs could be improved to strengthen the weaknesses of past efforts. However, the effectiveness of these strategies, even if restructured, remains uncertain. Furthermore, it is highly uncertain whether sufficient political support exists for renewed application of strong regulatory initiatives.

## Context

Some stakeholders have advocated for greater state regulation of health care spending and capacity to control the rate of growth in health spending. To provide context for a discussion of state regulatory options, Professor Frank Sloan presented a history of state health care regulation and a summary of the research literature. He discussed available evidence about what has worked previously and what hasn't, and shared his thoughts on future regulatory options. Stephen M. Weiner, who directed Massachusetts' hospital rate-setting program in the 1970s, discussed practical realities of operating that program, and laid out key challenges and future policy options in Massachusetts.

## Key Takeaways (Sloan)

- **Historically health care regulation has focused primarily on hospitals.**

After the implementation of Medicare and Medicaid in 1966, hospital expenditure rose rapidly, far exceeding expectations. Hospital cost containment rapidly became the focus of health care regulatory efforts. A key reason for hospitals' runaway costs in the 1970s was retrospective cost-based reimbursement. Paying hospitals based on their costs provided no incentives for efficiency and essentially supported a medical arms race.

- **From 1970 to 2000 states attempted to control health spending through certificate of need regulation and rate-setting programs—with limited effectiveness.**

### Certificate of Need Programs

State certificate of need (CON) programs as well as Section 1122 for Medicare and Medicaid were the key forms of health care market entry regulation. In 1974, states were required by federal statute to have CON laws (although this requirement expired in 1984). Under CON, health care providers were required to get state approval for new facilities and services or major construction projects like adding new hospital beds. CON programs vary by state, but often cover hospitals, nursing homes, home health agencies, and ambulatory surgery facilities. The initial goal of CON was cost containment, but this has evolved over time to include access and quality objectives.

Most state CON programs had important structural weakness which included:

- Poorly defined concepts of need that limited the effectiveness of CON for meeting policy goals. Without clear metrics to guide regulatory activities, these programs were more prone to political interference.
- CON programs covered only selected service categories, limiting the programs' impact on overall spending as providers could bypass regulation by shifting sites of service. For example, CON regulations frequently excluded physician offices, creating opportunities to set up new services in unregulated settings.
- CON programs generally did not establish capital budgets which would force them explicitly to consider trade-offs among competing projects.
- Although CON limited market entry, these programs had had little or no ongoing supervision of facilities once CONs



are granted. Applicants therefore may not have been held accountable for following all of the conditions set forth in their application (e.g., service volume, community benefit requirements etc.).

- Anti-competitive concerns, as the strongest supporters of CON were incumbents who supported the barriers to entry.
- CON did not correct capital market distortions (e.g. tax-subsidized interest rates).

While these structural weaknesses are significant, many of them are remediable. For example, states could:

- Require cost-benefit analysis for each project and for standard setting.
- Expand coverage at least to include capital in physicians' offices (e.g., MRIs).
- Implement a statewide capital budgeting process which would force state CON agencies to evaluate projects in a broader context, give them greater incentive to say no to projects of questionable value, and give them the ability to initiate projects to improve access.
- Increase monitoring of whether promises made as part of CON applications are kept and projections are reached.
- Limit terms for CONs and/or allow competitive bids.
- Collect information on facility quality, and disseminate to consumers.

After years of experience, there is empirical evidence on the impact of state CON programs on cost, access, and quality.

- *Cost.* The evidence shows that CON programs have not constrained cost growth. Research has shown that CON resulted in some reduction in the number of beds, but had no net impact on total hospital investment. The data show an increase in labor use attributable to CON. Overall, there has been no decrease in hospital cost per unit of output, and costs may actually have increased. Although some states have been reluctant to drop CON for fear of a spending surge, this has not been the experience of states that have ended their CON programs.

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*"CON does not constrain cost growth."*

— Frank Sloan

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- *Access.* There is limited empirical evidence on CON's impact on access. Even if CON regulators wanted to improve access by favoring applications located in underserved areas, these facilities would need continued financing to ensure their survival.
- *Quality.* The data around quality is mixed, but positive for cardiac services. One study (Ross, Ho, Wang et al [2007]) found that rates of questionable catheterizations were lower in states with CON.

Overall, the evidence on CON suggests that it has not been successful controlling costs, but that in some circumstances it has had a positive impact on quality. Nevertheless, there are many aspects of the historical design of CON programs that could be significantly improved. In general, Dr. Sloan suggested that CON should either be restructured or eliminated.

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*"We should either end it or mend it."*

— Frank Sloan

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### Rate-Setting Programs

The heyday of hospital rate-setting was in the 1970s and 1980s; only one of these programs remains active today. Among states with the most comprehensive systems, New York, New Jersey, and Massachusetts, all ended their programs in the 1990s. The last remaining state with comprehensive rate regulation is Maryland, which operates an all-payer system under a federal Medicare waiver.

Over the years a variety of rate-setting programs have been implemented with a range of characteristics. Rate-setting programs can be mandatory or voluntary. They may also be *regulatory* (i.e., payers and providers must abide by the rate-setting agencies decisions) or advisory (where the rate-setting process serves primarily to generate information). Programs could involve all payers or just some, and the unit of payment regulated could be individual services, per diem payments, per case payments, or overall hospital budgets. Rate-setting agencies have used both formula and budget review to establish payment rates.

Medicare's Prospective Payment System (PPS) was a per-case rate-setting program that replaced Medicare's prior predominantly cost-based reimbursement rules in 1984. While PPS only applies to the Medicare portion of hospital revenue (about 35%), PPS has been widely emulated by other payers.

Advantages of state hospital rate-setting include:

- Addressing, at least in part, the cost-increasing incentives of retrospective cost-based reimbursement.
- Potential reduction in waste.
- Potential savings in state budgets.
- Allowing for explicit treatment of cross-subsidies like charity care.

Disadvantages include the possibilities that rate-setting may:

- Introduce new inefficiencies into the system.
- Reduce incentives for innovation.
- Lead to distortions in the market because like CON it only applies to certain providers (hospitals) and not others.

The empirical evidence on rate-setting programs suggests some limited success controlling hospital spending:



- Rate-setting was initially implemented at a time when cost based reimbursement was the predominant form of hospital payment. In early studies, mandatory rate-setting programs reduced hospital spending with average effects ranging from 4% to 20%.
- However, by the mid-1990s, following the introduction of Medicare PPS and the growth of managed care, studies of rate-setting found little impact on hospital spending.

In conclusion, hospital rate-setting had initial success controlling costs, but its effectiveness declined with increased competition in the hospital sector. With one notable exception, in Maryland, state rate-setting programs are extinct.

Considerations for rate-setting in the 21<sup>st</sup> century include:

- Rate-setting does exist under Medicare PPS.
- Rate-setting could be applied to all private payers or all payers other than Medicare.
- The rate-setting models previously implemented by states are most applicable under a single payer system.
- Rate-setting could exist in a multi-payer system where bilateral negotiations occurred over prices. Individual payers would then focus on achieving decreases in utilization. (Germany has this type of system.)
- Negotiations could involve imposing maximum ceilings and allowing hospitals to price below the ceiling.

## Key Takeaways (Weiner)

- **Several factors contributed to ending rate-setting in Massachusetts.**
  - *Technical complexity.* Setting rates was difficult as the quality of data was poor and there was a lack of understanding about hospital cost drivers. Therefore, the formulas used to set rates were of necessity overly simplistic, adjusting principally for inflation and volume on an established cost basis. The formulas led to complaints from providers about the rates – providers felt there was inadequate recognition for costs beyond inflation and volume, and providers with lost costs bases due to efficient operations felt disadvantaged.
  - *Political complexity.* Initially regulators in Massachusetts had strong political support, even in the absence of good data to set rates, largely because rate setting was seen as a means of keeping Medicaid costs under control. But over time, as hospitals saw the regulations as unfair, increasing legislative intervention significantly increased the complexity of the formulas and regulation became “out of control.” Then a new Governor was elected who favored deregulation, and the rate-setting program, lacking political support, ultimately collapsed.
  - *Growth of managed care.* The corresponding growth in managed care, which included a major focus on negotiating

lower rates with hospitals, decreased the utility of rate-setting and led many to see it as unnecessary.

- **There is limited support for bringing rate-setting back in Massachusetts.**

Since the rate-setting system ended, there have been improvements in data systems and in our understanding of the technical aspects of hospital reimbursement. Medicare has developed some techniques for controlling hospital costs, although in doing so it has created a complex set of methodologies. Importantly, there is still a substantial lack of understanding about hospital cost drivers, and there are numerous technical and political concerns about how a newly established state-level rate-setting system would work. There are also philosophical questions:

- *Is this a private sector issue?* The reason that states got into rate-setting was because the private sector was not able to control costs. Although costs leveled off in the period preceding deregulation, they are now rising rapidly again. The question is, “Is this a private sector issue or an issue where states should regulate?”
- *Can regulation really solve the problem?* Health care is complex, and bringing spending under control while preserving quality and access requires a multi-faceted approach. In this context, it is not clear whether state rate-setting would be helpful, a costly distraction, or an inhibition to reform.

In Mr. Weiner’s option, there presently appears to be little support for returning to a highly regulatory rate-setting structure in Massachusetts.

## Participant Comments

- **Effects of market competition.** The health care market is very different today than when state rate-setting was initiated. Hospitals represent a smaller share of health care costs; there is less excess capacity; and there has been significant payer consolidation. For these reasons, there is even less rationale for regulation.
- **Utilization as the focus of cost management.** One participant suggested that the driver of health spending is not necessarily rates, but rather unnecessary utilization. If this is true, then the key to controlling spending lies not in setting rates but in managing utilization. Efforts to manage use cannot be limited to hospital services, but must include outpatient care as well.



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