Testimony on Proposed Revisions in
Massachusetts Determination of Need Regulations,
105 CMR 100.000 – 100.825

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As always, I write personally, not on behalf of any Boston University or any of its components.

A. General comments

The Department of Public Health proposes new Determination of Need (DoN) regulations. These are doubtless well-intentioned, and they do promise improvement in some areas. But they are flawed in some things they do and, even more, in other things they don't do. Some flaws stem from elements of the regulations themselves; others from the state's Determination of Need Statute; and still others from the incoherent condition of health policy, politics, finance, and economics in our state—both in government and out. The draft regulations signal a lost opportunity because DoN is one of the few tools available to state government today to influence the shape of Massachusetts health caregivers.

The proposed regulations—and state officials' comments on them—properly note important ways in which both the health care environment in Massachusetts and the activities of other state health care agencies affect both DoN generally and the proposed regulations specifically. For the same reasons, this testimony briefly examines the proposed regulations in the context of the state's health care environment and of other state health care agencies.

The first general comment is that the new regulations—like the old—are fairly weak. They do little to slow the rise of health care costs in Massachusetts or to shift care in more effective and accessible directions, especially if the political will to enforce them remains weak—as it has been for decades.

Second, they rest, ultimately, on an approach to regulating health care capital first adopted in Massachusetts in 1971 and little changed subsequently.

The draft regulations make some positive changes. But their shift toward promoting competition is unlikely to have its desired effects on lowering prices. Instead, this shift is likely to require steady and wasted infusions of capital to build and sustain unneeded hospital and other caregiver capacity in hopes of inducing caregivers to compete by price.

Serious efforts to promote price competition would require very substantial break-up of large vertically and horizontally integrated organizations everywhere they exist. In particular, dividing Partners into two competing systems, only one a must-have for insurers, would do vastly more to promote price competition than the marginal actions of the draft regulations and the rhetoric supporting them. This division of Partners would reverse 20 years of state government's largely passive acceptance of past mergers, its continued endorsement of recent mergers, and even its more recent mild skepticism about some proposed mergers.

Third, the draft regulations are not guided by overall strategies that are tested, widely accepted, and backed by political commitment to better spend health care dollars in our state—spending that has long been—and today remains—highest in the world. No such strategies exist in Massachusetts today.

One reason might be that our state's health costs are publicly portrayed as substantially lower than they really are reported to be by federal government measurement. State government's definition of Total Health Care Expenditures (THCE) does not include all health care expenditures. This was not done to deceive. The state is clear about what it is measuring, how, and why. But the unintended effect is to make health care spending here look lower than is reported federally. For example, CHIA has reported 2015 TCHE at $57 billion statewide or $8,441 per person.

Suppose, conservatively, that personal health spending on Massachusetts in 2015, which includes all but one of the items falling under THCE, plus a number of others, has fallen from its 2009 excess of 36 percent over the national average to 34 percent over, owing to catch-up ACA implementation elsewhere. Personal health care spending in Massachusetts in 2015 would then be $76.5 billion, or 30 percent above the state's reported THCE of $57 billion. Personal health care spending per person would be about $11,257, one-third above the state's THCE per person.

Fourth, therefore, the draft regulations take their place as one element among an incoherent and uncoordinated set of actions—mainly constituting hand-waving—in the general direction of more effective and affordable health care for all.

Fifth, Massachusetts health care is descending deeper into anarchy. This is owing mainly to the general absence of either genuine free market competition or competent government action in health care. This requires a brief separate, discussion

Health care anarchy has become the default alternative to functioning competitive markets or competent government

The initial impetus toward health care anarchy comes from comprehensive failure of the competitive free market to function in health care. Not one of the six requirements for competitive free markets is close to met in health care.

- ✓ Free markets require lots of small buyers and sellers, so the market makes prices and determines volumes. Consequently, all parties pay or receive one market price. But health care is increasingly dominated by fewer and larger buyers, all trying to leverage price in their favor.
- ✓ Free markets require sovereign, independent buyers and sellers who spend their own money. But patients necessarily depend on doctors' advice, and patients' costs are buffered by insurance—without which, many or most of us could not afford needed care.
- ✓ Free markets require easy entry, so that monopolists are challenged by new entrants. But entry barriers in health care are high.
- ✓ Free markets require buyers and sellers who are well-informed about price and quality. But these are hard to learn in health care—especially for patients.
- ✓ Free markets require prices that track cost, so buyers who choose by price and quality reward efficient producers. But health care prices often bear little relation to underlying costs.
- ✓ Free markets require that "buyers beware" and mistrust their doctors and nurses and dentists. But patients who trust their clinicians are likelier to fare better.

Lacking a genuine free market, some well-intentioned people substitute their declared "belief" in the market—as if faith would heal Massachusetts health care. This is understandable. The market's theory is seductive. Markets promise self-regulating pursuit of equilibrium, creative innovation, winnowing what works, pursuit of efficiency, and satisfaction of consumer demands.

But without a functioning competitive free market, those who do well financially in health care today vainly imagine that a theoretical invisible hand is applauding their achievements. That is the sound of one hand clapping. Those who do badly often wrongly blame themselves and quietly retire to the shadows.

It is fundamentally misleading, distracting, and unsound to use of the words "market" and "competition" in reference to health care today. The words "provider" and "consumer," ironic relics of community health planning, are equally misleading.

Many market believers recognize the market's many weakness in health care and work to buttress it. Unfortunately, their main tool is to oblige humans, when ill, to spend more out-of-pocket in hopes they will shop more carefully—as informed consumers--by price and quality. Wielding this tool is misguided in its intent and cruelly unjust in its impacts. Worse, many

market believers apply a double standard—one for individual citizens and patients, and the other for powerful hospitals.

Boosting out-of-pocket costs predictably has had the effect of lowering use of care across the board, without clinical discrimination by whether the care is needed. Worse, lower-income people cut back more sharply. That's no surprise, since any given dollar deductible, co-insurance, co-payment, or annual out-of-pocket maximum is a greater share of the income of a lower-income person than of a higher-income person. The policy is clearly discriminatory on grounds of income.

Blindly, out-of-pocket costs have been raised without first making available information about price and quality of care that are reasonably useful to reasonable people. After years—even decades—of talk, clear price and quality data that humans can and will use are still largely unavailable. This wide, deep, reckless, and prolonged failure amounts to cynically telling sick people to go play in traffic.

Advocates of markets rely on boosting out-of-pocket burdens on individual citizens and humans, when sick, to increase competition because the alternative—fighting to dismantle massively vertically integrated hospital – doctor systems—is too tough a political fight. Individual citizens find it hard to organize, lobby, produce self-sanctifying advertisements, make campaign contributions, or threaten to sue.

Winners or sinners? Without a functioning free market, hospitals can succeed financially and grow in capital facilities and numbers of patients served without being efficient and without satisfying consumer demands. To automatically anoint these hospitals as winners in the market is a mistake. They may actually be sinners. We don't know. There's no functioning market we can trust.

It seems clear that one reason Massachusetts General and Brigham and Women's hospitals enjoyed many years of high surpluses and accumulating wealth is their 1994 merger, which they undertook to gain leverage over non-public payers, so they could extract higher prices. They succeeded.

Six months after that merger, Harvard Community Health Plan and Pilgrim Health Care merged in an effort to boost their own leverage over newly-powered hospital systems. Other clusters of hospital mergers followed in hopes of imitating Partners' ability to extract high prices from private insurers and HMOs.

Today, of some 65 surviving acute care hospitals (down from 140 when President Kennedy was elected), fully 50 (77 percent) are in multi-hospital systems of varying sizes and only 15 are independent. The five largest systems—Partners, BI-Deaconess/CareGroup, Baystate, UMass-Memorial, and Steward—comprise 33 hospitals (just over half) and a substantially greater share of care and cost statewide.

Fewer competitors mean less competition, more oligopoly.

Do the large new hospital – doctors systems provide fine care? Very often. Do they serve patients who could be cared for in less costly settings? Sometimes. Are they durably affordable? Probably not. Can we afford to allow them to conduct their business as usual? No.

Will modifying DoN regulations in hopes of spurring a little more competition in some areas of care do much to actually attain greater competition? Not much. Hospitals have spent decades in merging and reorganizing in large part to nullify theoretical efforts to force them to compete by price and quality. They have largely succeeded. Why should we expect a different outcome this time?

Especially political pressure to contain Massachusetts health care costs is weak.

In absence of anything approaching a genuine competitive free market in most sectors of health care, competent government action is the main current alternative to growing anarchy in health care costs, access, appropriateness and quality, and configuration of various caregivers. (Configuration refers to the numbers, types, and locations of caregivers.)

If a hospital or other caregiver proposes a specific new capital project, it is difficult to assess need for the care that project could add or preserve in the absence of evidence of need for a) acute inpatient capacity, b) surgical capacity (inpatient surgery, in-hospital ambulatory surgery, and free-standing ambulatory surgery), nursing home capacity, and other caregiving capacity.

Determination of need is provides the power to say "no" or "yes" to hospitals that can afford a capital project or an added service. It does nothing to enhance the capacity of impoverished caregivers to propose capital spending they cannot now afford—but that might be clinically valuable, might be a way to enhance access, and that might actually deliver care in a less costly manner.

Unable to help financially weak hospitals and rarely willing to say no to financially strong hospitals, the determination of need program has done little, over the years—despite the dedicated efforts of many individuals—to make Massachusetts health care more accessible, affordable, or effective.

The main cause of this specific failure is political. The political will to say "no" to costly new hospital capital projects is weak.

- ✓ When those projects are proposed by powerful teaching hospitals that promise better care and that decry older inpatient rooms or cramped operating rooms or tiny emergency rooms
- ✓ Power of hospitals, construction companies, and workers
- ✓ Ignorance of the altitude to which our state's health care costs have climbed
- ✓ Blind faith in a competitive free market in health care that does not exist

- ✓ Coupled with weak—and probably vain—efforts to rely on sick people to spend money more carefully
- ✓ And with weak efforts to stave off growing concentration in health care—by tolerating anti-competitive hospitals mergers.

In recent years, state health policies have begun finally to recognize decades of accumulating evidence that concentration of care in costly teaching hospitals is one important source of high Massachusetts health costs. So far, unfortunately, this recognition has been accompanied only by weak or symbolic action to reverse that trend.

One summary test of the draft regulations is whether applying them to various actual DoN applications approved or disapproved in the past would have resulted in any meaningful reversals in those past decisions—or any different consequences for health care cost, access, appropriateness or quality, or caregiver configuration in Massachusetts.

If the consequences would not be very different, the draft regulations might mainly signal movement without progress, a chronic problem in U.S. health care.

B. Comments on the draft DoN regulations

Six facets of the draft regulations are considered here. According to DPH, the draft regulations

1. Promise to be more modern, streamlined, and brief regulations, and to provide a speedier regulatory process.

It is hard to argue with those ideas, other things equal.

2. Promise to take a more careful look at proposed mergers—looking beyond questions like whether a hospital is needed and whether a merger is the best way to keep it open—and considering the merger's effects on costs by more formally integrating analysis from the HPC.

Unfortunately, mergers will be politically popular when they appear to be the only way to preserved a strongly supported local hospital. This might be particularly true of our states 15 or so surviving free-standing community hospitals. But it could also prove to be true of mergers engineered to preserve an important teaching hospital—one serving dozens of thousands of patients and employing thousands of workers—that is sliding toward bankruptcy.

The real bankruptcy here is political and financial—that the state with the world's costliest hospitals has been unwilling and unable to identify which hospitals are needed, and to ensure that

all such hospitals are paid revenue adequate to finance efficient provision of effective care. In this climate, a merger can look good because each alternative looks worse. The proposed DoN regulations do nothing overcome these sad realities.

Instead, we can expect to hear more statements like "bankrupt hospitals deserve to close." Such statements rest on the fierce but wrong-headed notion that a competitive free market functions in health care and rewards efficient hospitals that address sovereign consumer demand.

3. Promise to provide tougher ways to enforce conditions attached to approved DoNs, with non-compliance with conditions resulting in added financial penalties—to be used for community health initiatives.

But a 2.5 percent penalty for non-compliance would amount to only $25 million on a $1 billion project such as the one that is apparently about to be approved for Children's Hospital. A hospital that is able to borrow and spend $1 billion in new capital—and one with over $3 billion in net assets (apart from property and equipment)—can afford to pay a $25 million fine or threaten to tie up the fine in court for a number of years. And statewide spending on the community health initiatives—however valuable individually—has totaled only about $15 million annually for the past dozen years.

4. Promise lower prices by approving new capacity that promotes price competition among caregivers.

Unfortunately, and as discussed earlier, that new capacity to enhance price competition entails added capital and operating cost. In time, caregivers tire of competing. Capacity drops. Price rises. New excess capacity must be financed to recreate another transient period of excess capacity.

In a few instances, one hospital may wish to compete with another for this service or that. Such a wish could engender a DoN application. More generally, though, caregivers' dislike of being forced to compete by price and quality is greater than state government's willingness and ability to oblige them to do so. And DoN can only approve projects that hospitals seek permission to undertake. It can't push on a string and somehow extract applications from hospitals.

In health care, unlike sectors of the economy where something close enough to a functioning free market actually operates, maintaining excess capacity is both expensive in itself and remarkably inefficient as a mechanism to lower prices.

One efficient way to lower prices is by either negotiating them down through regular meetings of organized payers and organized caregivers—with government serving as referee. A second way is by negotiating global static budgets for hospitals, as Maryland has done. That has the added

benefit of making health dollars so fungible they can be used to keep patients stable and out of the hospital. This illustrates the vital point that cost control and careful spending do not require putting financial risk on hospitals or other caregivers. Accountability to spend inevitably finite dollars—to do as much as possible to address remorseless pathology, disability, and pain—is a sufficient spur to careful spending.

5. Promise to help community hospitals compete by emphasizing clinical value and prices of services.

Unfortunately, once again, DoN can only approve projects that hospitals seek permission to undertake. It can't push on a string and somehow extract applications from hospitals. In particular, it can't force those community hospitals that are financially distressed to apply for DoNs to launch or expand services where they might be price competitive. Worse, such new or expanded services might prompt larger teaching hospitals at risk of losing patients to set prices at low, even predatory levels. Many larger teaching hospitals have the reserves to underwrite losses for a considerable time. The opacity of hospital pricing would make it hard for regulators to find evidence of predatory pricing—if that were willing and able to look for it.

6. Promise to expand freestanding ambulatory surgery capacity only by or with existing hospitals, not by entities other than hospitals.

If ambulatory surgery capacity is to be added, it makes a great deal of sense to allow only hospitals to do so—preferably alone or, if with others, requiring that the hospital own at least 51 percent of the project. First, ASCs might be efficient or, at least, profitable. In Pennsylvania, they were roughly six times as profitable as hospitals in 2010. More efficient operation is one possible reason. A second is higher revenue, stemming from higher prices associated with a payer mix much richer in commercially insured patients and much leaner in Medicaid patients.

Keeping ASCs under hospital ownership allows those hospitals to earn surpluses on the ASCs and use those surpluses to subsidize provision of money-losing care in other locations. That's because most hospitals have wider and deeper responsibilities to provide care to large and heterogeneous groups of patients than do free-standing ASCs .

It is also useful to note a few things the draft regulations do not do.

First, they do little to change the standard of absolute need and do not move far toward relative need. Section 100.210's factors mention demonstrating "sufficient need". And "relative merit" is a factor—but this is the familiar need to show that the applicant's chosen method of meeting need is superior to others it might have adopted.

All this is understandable in light of the statutory standard. A standard of absolute need sounds tough, but it is not. The applicant need demonstrate only that a medical need is met.

What is lacking is any shift toward weighing and comparing different hospitals' or other organizations' patients' need for building, equipment, or services. This approach would allow hospitals that can't meet the DoN factor of financial feasibility today to apply for permission to acquire new capital or launch or expand services.

The easiest way to do that would be to create a capital budget—a fixed dollar pool to pay for health care capital annually. Applicants for capital would identify and propose ways to spend that money. Applicants making the strongest cases would be financed; others would not. This would be meaningful competition. It is absent in the draft regulations. That is not surprising. Such an approach would not be fully consonant with current statute.

DoN should do more than weigh relative need. DoN itself should tie regulatory approval to project financing. A capital budget should finance the most promising projects. This does not increase spending on health care capital or operations. It merely changes the pocket from which the payments for capital are taken.

Making that competition real would entail public financing of health care capital from a dedicated pool of money. This would enable needed caregivers with worthy projects to obtain capital financing, irrespective of their current operating margins, net assets, or bond ratings. Given that those financial measures are not today blessed by a functioning competitive free market, public intervention to assure equitable access to capital is essential to preserving needed, low-cost, and financially distressed caregivers.

Today, applicants without money don't apply for DoNs. DPH does not get to say yes to those projects. It does not have to say no. That is a highly skewed or asymmetrical DoN process, one that surely fails to do as much as possible to marshal current spending to advance provision of accessible, efficient, needed, and high-quality care throughout our state.

Importantly, public financing step would markedly reduce pressure on hospitals to put on gang colors and merge so they can continue to walk safely around the health care neighborhood.

Even more importantly, this step would help to refocus capital projects on raising the floor—the worst we are willing to tolerate in our health care for anyone—instead of continuing the long-standing focus on raising the ceiling—the best possible care for some.

Second, moves toward coordinating with Health Policy Commission on important matters could be very helpful in the future, but they are helpful today only in limited ways, such as review of effects of proposed hospital mergers.

One reason is that state government actions to regulate, influence, or re-shape health care are undertaken without guidance on agreed goals or how to attain them. For example, the state does not know how many emergency rooms, in what locations, are essential to protect the health of the public. Nor does it know needed hospital inpatient capacity, ambulatory surgery capacity. Nor does it know the number of available FTE primary care physicians, where they are located, how many are needed today, or the size of the shortfall five or ten years hence.

Does no one in state government have the duty or legislative mandate to inventory current health care capacity or identify important types of excess capacity, shortages, or financially vulnerable caregivers whose survival is essential to averting capacity shortages?

Third, one latent, quiet function of DoN regulations is to try minimize, to the extent possible, either caregiver grievances with DoN or public conflicts about decisions to grant or deny DoNs. One way to do this is by trying to provide hospitals and other caregivers with reasonably clear guidance about what capital projects or changes in service are likely be approved and what are likely to be denied. A way to do this is by trying to write rules and make decisions that are seen as balanced, such that no caregiver or group of caregivers are perceived to have been unfairly advantaged or harmed. Or goes to the courts, the media, or the legislature to seek relief.

Caregivers are the parties most likely to be aggrieved or to perceive themselves to be disadvantaged by DoN decisions. But the public—which pays almost all the cost for health care by premiums, taxes, or out-of-pocket—is not likely to be very aware of its stake in the process. Its interests might therefore receive inadequate attention. To what degree is this true of the draft regulations?

C. Alternative elements to consider—mostly requiring legislative action

What good is a newly engineered DoN highway if it fails to connect where we are—in the state with the highest health care costs in the world—to where we need to get—more affordable and accessible care for all citizens of the Commonwealth?

Key reforms in regulating and financing health care capital spending include

1. Shifting to a standard of relative need for capital from today's standard of absolute need. Hospitals and other caregivers would compete annually for a finite pool of money. Merit would matter more than money. Efficient provision of needed care, accessible for all, would trump financial capacity. This would help preserve needed but under-financed caregivers. It would help to enhance attention to raising the floor and reduce attention to raising the ceiling.

2. Making it easier for needed but impoverished hospitals to obtain capital they require to maintain or rebuild their inpatient, outpatient, and emergency facilities; to buy needed

equipment; and to attract the physicians needed to serve patients, generate revenue, and sustain themselves as vital caregiving institutions.

3. Financing hospital capital in more sensible ways. A large share of hospital capital should be raised through an assessment on hospital revenues and assets. Since health care prices and revenues are unevenly distributed—in ways unjustified by either an honest competitive free market or quality of care—revenue to finance hospital capital should be raised in proportion to where the money is located.

At the end of hospital fiscal year 2015, statewide total net assets of hospitals were $15.7 billion. A one percent assessment on this wealth annually would yield just over $150 million each year. (And these sums may not include reserves lodged in hospital holding companies.)

Similarly, hospitals' HFY 2015 net patient service revenue was roughly $23.2 billion. An annual assessment of 0.25 percent would raise nearly $60 billion yearly.

Together, these complementary assessments would raise a little over $200 million yearly. That would finance many needed capital projects each year at smaller and financially distressed hospitals, community health centers, or long-term care facilities.

One approach would be to use the money to pay cash for $200 million annually in capital projects. Alternatively, that $200 million assessment each year could be used to pay annual principal and interest costs on some $3.1 billion in outstanding health care debt, financed at 5 percent interest over 30 years, for a self-amortizing loan.