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Participatory Procedure and Political Support for Hospital Cost Containment Programs: Limits of Open Administrative Process

Stephen M. Weiner

PARTICIPATORY PROCEDURE AND POLITICAL SUPPORT FOR HOSPITAL COST CONTAINMENT PROGRAMS: LIMITS OF OPEN ADMINISTRATIVE PROCESS

STEPHEN M. WEINER†

I. INTRODUCTION

A. "Reluctant Agencies" and "Reformist Agencies"

A principal concern of modern administrative law is the capability of persons interested in and affected by administrative actions to have adequate opportunity to present their views in the agency's decision-making processes. This concern is reflected in major doctrinal developments concerning the standards applicable to judicial review of the actions of administrative agencies possessing broad statutory grants of discretionary authority.[1] Similar concerns are reflected in efforts to fashion judicial and statutory principles intended to extend the legal

† Associate Professor of Law, Boston University School of Law; Director, Center for Law and Health Sciences, Boston University School of Law. A.B. 1964, Harvard College; LL.B. 1968, Yale University. The author gratefully acknowledges the assistance provided by Thomas Lewis, J.D., and Mark E. Cohen, J.D. Candidate, Staff Attorney and Research Assistant, respectively, at the Center for Law and Health Sciences, Boston University School of Law. Funds for their work were provided by the Health Care Financing Administration, United States Department of Health, Education and Welfare, through the University Health Policy Consortium, Waltham, Massachusetts.

1. *See, e.g.*, Citizens to Preserve Overton Park, Inc. v. Volpe, 461 U.S. 402 (1971), in which the Supreme Court discussed the relevant standard applicable upon judicial review of an agency action—in that case, the determination of the Secretary of Transportation to authorize federal funds to construct a highway through Overton Park in Memphis, Tennessee. Construing the provisions of § 10(e)(2)(A) of the Administrative Procedure Act, 5 U.S.C. § 706(2)(A) (1976), that an action may be overturned if found to be "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law," the Court stated:

> To make this finding the court must consider whether the decision was based on a consideration of the relevant factors and whether there has been a clear error of judgment. Although this inquiry into the facts is to be searching and careful, the ultimate standard of review is a narrow one. The court is not empowered to substitute its judgment for that of the agency.

Id. at 416. *See also* Wright, *The Courts and the Rule-making Process: The Limits of Judicial Review*, 59 CORNELL L. REV. 375 (1974).

The standard enunciated by the Supreme Court suggests two principles: that in arriving at its decision the agency should give evidence that it has considered various perspectives on the relevant issue before the agency, not merely the views of one of the affected parties; and that the

capacity of interested parties to participate effectively in agency proceedings.[2] The multiple sources for this concern include the following: the belief that agencies, particularly regulatory agencies, tend to favor better organized and better financed interests at the expense of inadequately represented perspectives[3]; a sense that administrative agencies become increasingly isolated from and indifferent to outside interests, that is, become "bureaucratized" and pursue their own self-interest[4]; the recognition that governmental agencies require access to multiple sources of information to ascertain what is in the public interest, and that this information is best provided by directly affected interests[5]; a

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reviewing court's responsibility is nonetheless a narrow one, not permitting it to question the policy judgments of the agency to the extent there has been no "clear error of judgment." *Id.*

For a discussion of the meaning of "clear error of judgment" in *Overton Park* and the possible confusion arising from the Court's use of that term in the context of that case, see Ethyl Corp. v. EPA, 541 F.2d 1, 34 n.74 (D.C. Cir.), *cert. denied*, 426 U.S. 941 (1976).

With respect to the first principle gleaned from the *Overton Park* standard, compare Automotive Parts & Accessories Ass'n v. Boyd, 407 F.2d 330 (D.C. Cir. 1968), in which, in the context of a rulemaking proceeding, the court stated that one of its functions was to assure that "the disappointed have had the opportunity provided by Congress to try to make their views prevail." *Id.* at 343.

2. With respect to standing to participate in an agency proceeding, see Office of Communications of the United Church of Christ v. FCC, 359 F.2d 994 (D.C. Cir. 1966).

With respect to the financing of public participation in agency proceedings, see 15 U.S.C. § 57a(h)(1) (1976) (financing of public participation in Federal Trade Commission proceedings); W. GELLHORN & C. BYSE, ADMINISTRATIVE LAW: CASES AND COMMENTS 729-30 (6th ed. 1974).

With respect to standing to challenge an agency action, see Simon v. Eastern Kentucky Welfare Rights Organization, 426 U.S. 26 (1976); United States v. SCRAP, 412 U.S. 669 (1973); Sierra Club v. Morton, 405 U.S. 727 (1972); Association of Data Processing Serv. Organizations v. Camp, 397 U.S. 150 (1970).

With respect to efforts to assure that adequate consideration is given to all affected interests, see Automotive Parts Accessories Ass'n v. Boyd, 407 F.2d 330 (D.C. Cir. 1968); Office of Communications of the United Church of Christ v. FCC, 359 F.2d 994 (D.C. Cir. 1966). *See also* ADMINISTRATIVE CONFERENCE OF THE UNITED STATES, 1971-1972 REPORT at 11-12, 37-38 (1972).

Further indications of the movement toward enhancing the possibility and quality of general public participation in agency proceedings include the trend toward favoring rulemaking over adjudication as the mode for agency policy development, *see* National Petroleum Refiners Ass'n v. FCC, 482 F.2d 672 (D.C. Cir. 1973), *cert. denied*, 415 U.S. 951 (1975), and enactment of the Freedom of Information Act and its subsequent amendment to strengthen the public's capacity to obtain disclosable agency documents, *see* Pub. L. No. 89-554, § 552, 80 Stat. 383 (1966) (codified as amended at 5 U.S.C. § 552 (1976)).

See generally Stewart, *The Reformation of American Administrative Law*, 88 HARV. L. REV. 1667, 1723-90 (1975).

3. *See* Moss v. CAB, 430 F.2d 891, 902 (D.C. Cir. 1970); Office of Communications of United Church of Christ v. FCC, 425 F.2d 543, 549-50 (D.C. Cir. 1969); G. ROSENBAUM, THE POLITICS OF ENVIRONMENTAL CONCERN (1973); Cramton, *The Why, Where and How of Broadened Public Participation in the Administrative Process*, 60 GEO. L.J. 525 (1972); Stewart, *supra* note 2, at 1684-85; Danfield, *Representation for the Poor in Federal Rulemaking*, 67 MICH. L. REV. 511 (1969).

4. E. TROXEL, THE ECONOMICS OF PUBLIC UTILITIES 69-70 (1947); Cutler & Johnson, *Regulation and the Political Process*, 84 YALE L.J. 1395, 1404-05 (1975); Leone, *Public Interest Advocacy and the Regulatory Process*, 400 ANNALS 46, 50-51 (1972).

5. G. STIGLER & F. COHEN, CAN REGULATORY AGENCIES PROTECT THE CONSUMER? 15

skepticism that the minimal notice and comment provisions of traditional administrative rulemaking procedures are not conducive to a broad public awareness of the significant policy issues that the agencies are addressing[6]; and the increasing technical sophistication of agencies and the incapacity of many interested parties, absent highly developed organizational and financial resources, to provide useful comments.[7]

These concerns generally proceed from what may be considered the model of the "reluctant agency." This is an agency that possesses significant discretionary authority vested by statute and that chooses, deliberately or otherwise, to exercise its authority for the benefit of the most economically and politically influential groups affected by its decisions. This may be done passively by relying, for example, on ambiguous statutory mandates for change to justify making no change, perpetuating thereby the prevailing power relationships[8]; or it may be done actively by specifically making decisions to favor strong interests.[9] In either circumstance, the agency is able to effectively preclude meaningful participation in its policy development and decisionmaking processes by less powerful or articulate groups.[10] Critics of this type of agency assume, at least in part, that increased participation by more diverse interests may modify the substance of agency decisions.[11]

Not all administrative or regulatory agencies, however, fall into the model of the "reluctant agency." Some agencies, at least during some periods of their history, determine to exercise their discretionary

(1971); Stewart, *supra* note 2, at 1686; Gellhorn, *Public Participation in Administrative Proceedings*, 81 YALE L.J. 359, 377-78 (1972).

6. *See, e.g.*, United States v. Nova Scotia Food Products Corp., 568 F.2d 240, 251-52 (2d Cir. 1977); National Welfare Rights Organization v. Mathews, 533 F.2d 637, 648 (D.C. Cir. 1976); Rodway v. U.S. Dep't of Agriculture, 514 F.2d 809, 814, (D.C. Cir. 1975).

7. *See, e.g.*, J. MASHAW & R. MERRILL, INTRODUCTION TO THE AMERICAN PUBLIC LAW SYSTEM: CASES AND MATERIALS 292-93 (1975).

8. *See generally* Rosenblatt, *Health Care Reform and Administrative Law: A Structural Approach*, 88 YALE L.J. 243 (1978).

9. G. SCHUBERT, THE PUBLIC INTEREST 119 (1960); Green & Nader, *Economic Regulation vs. Competition: Uncle Sam the Monopoly Man*, 82 YALE L.J. 871, 876 (1973). *See also* Geller, *A Modest Proposal for Modest Reform of the Federal Communications Commission*, 63 GEO. L.J. 705 (1975).

10. Support for this result of agency action or inaction may have been provided in part by the Supreme Court in Vermont Yankee Nuclear Power Corp. v. Natural Resources Defense Council, Inc., 435 U.S. 519 (1978). The decision, establishing the specific requirements of the APA as maximum procedural requirements, may cast doubt on the continuing validity of such cases as Mobil Oil Corp. v. FPC, 483 F.2d 1238 (D.C. Cir. 1973), but would not appear to affect the trends and policies described in notes 1 & 2, *supra*. *See also* Rosenblatt, *supra* note 8, at 322-26.

11. Rosenblatt, *supra* note 8, at 255.

authority to reallocate economic power.[12] These "reformist agencies" are characterized by: (1) a willingness to perceive the "public interest" as other than the interests of the dominant firms in the regulated industry; (2) efforts to develop procedural devices for encouraging broader participation in and awareness of the significance of decisionmaking processes that the agency undertakes; and (3) attempts to produce decisions that may substantially alter customary practices or traditional relationships in the industry subject to regulatory authority.

One may expect a reformist agency to generate considerable political opposition as it engages in efforts to reallocate existing political and economic resources. To a substantial extent, it may be theorized, its success depends on the explicitness of its statutory authority, the extent to which that statutory authority represents a continuing public political commitment to the agency's objectives, and the relationship between industry interests and nonindustry interests in monitoring and evaluating the agency's activities.[13]

Much analysis of administrative law focuses on the "reluctant agency."[14] Relatively little study has been devoted to the reformist model, particularly the political process that surrounds the reformist agency's efforts to achieve its objectives. This article will consider only one type of reformist agency, that concerned with hospital cost containment, and will focus specifically on a relatively limited question: whether openness of the agency's decisionmaking processes to broad public participation—an objective sought by many of the critics of the reluctant agency[15]—correlates with general political support for the agency's programs and objectives. The article is not intended to provide a detailed framework for analysis of the "reformist agency" model, but to serve as a starting point for further analysis.

B. Hospital Cost Containment Agencies as "Reformist Agencies": The Massachusetts Experience

Many of the health regulatory agencies concerned with hospital cost containment objectives tend, at least initially, to fall within the "re-

12. *See* Lazarus & Onek, *The Regulators and the People*, 57 VA. L. REV. 1069, 1083-84 (1971) (description of role of Federal Trade Commission under chairmanship of Miles Kirkpatrick).

13. *See* M. BERNSTEIN, REGULATING BUSINESS BY INDEPENDENT COMMISSION 263-71 (1955).

14. *See, e.g.*, Citizens to Preserve Overton Park, Inc. v. Volpe, 401 U.S. 402 (1971); Moss v. CAB, 430 F.2d 891 (D.C. Cir. 1970); Office of Communications of the United Church of Christ v. FCC, 425 F.2d 543 (D.C. Cir. 1969); Lazarus & Onek, *supra* note 12.

15. *See, e.g.*, Lazarus & Onek, *supra* note 12.

formist" model: many agency policymakers perceive their role as attempting to restructure traditional relationships in the hospital service delivery system as a means of achieving cost containment objectives. In Massachusetts, for example, a variety of statutory and administrative programs have developed over the past eight years that attempt to alter traditional power relationships and decisionmaking processes in the hospital sector.[16] The programs have sprung up out of concern for the adverse societal and economic consequences of rapid increases in hospital costs[17]; their cost containment objectives are thus viewed as being in accord with the "public interest." The logical products of such a commitment are efforts to produce a restructuring of the hospital delivery system and a realignment of existing economic relationships.

Two programs have been established by explicit statutory authority; a third effort, which is not yet sufficiently coherent to warrant being called a "program," encompasses attempts to shrink the size of the existing hospital sector by closing or merging services or whole institutions.

The two explicit statutory programs are "determination of need" (DON)[18] and hospital budget review and approval (Chapter 409).[19] DON is administered by the Department of Public Health (DPH), and provides for review and approval by DPH of hospital applications to undertake substantial capital expenditures and substantial changes in service.[20] Under the Chapter 409 program, hospitals must annually file their budgets for review and approval by the Massachusetts Rate Setting Commission (RSC).[21] Both programs emerged from legislative concerns about the cost of hospital care,[22] and therefore commenced

16. *See, e.g.*, Health Planning and Policy Committee of the Commonwealth, Health Care Expenditures in Massachusetts 28-43 (1976).

17. *Id.* at 25-27.

18. MASS. ANN. LAWS ch. 111, §§ 25B-25G (Law. Co-op 1975 & Cum. Supp. 1978).

19. *Id.* ch. 6A, §§ 37-44 (Law. Co-op Cum. Supp. 1978).

20. The two jurisdictional terms "substantial capital expenditure" and "substantial change in service" are defined in *id.* ch. 111, § 25B (Law. Co-op 1975 & Cum. Supp. 1978).

21. *Id.* ch. 6A, § 39 (Law. Co-op Cum. Supp. 1978).

22. *See* Joint Special Committee Established to Make an Investigation and Study of Health Benefits and Health Services for Every Citizen of the Commonwealth and Related Matters, Interim Report, H. No. 5968 (June 1972) (DON) [hereinafter cited as Interim Report of the Joint Special Committee]. The history of Chapter 409 began with Law of July 9, 1975, ch. 424, § 10, 1975 Mass. Acts 449, which directed the Secretary of Human Services to submit "a proposal for a comprehensive system for controlling the costs of purchasing hospital care in the commonwealth." The proposal was submitted in October, 1975, together with draft legislation. *See* A Proposal From the Secretary of Human Services for a Comprehensive Plan for Controlling the Cost of Purchasing Hospital Services in the Commonwealth (1975). The draft legislation was revised and resubmitted by the Governor in 1976 as H. No. 3160, which became the basis for hearings and deliberations eventually producing Law of Oct. 15, 1976, ch. 409, 1976 Mass. Acts 522.

operations with a background of public support for their objectives. While it may be hypothesized that, even with their reformist objectives, they would not necessarily fall into the model of "reformist agencies,"[23] it does appear that both the DPH and the RSC have taken their responsibilities seriously in making efforts to retard increases in hospital expenditures.[24] Since hospitals have become accustomed to making their own decisions on expenditure levels,[25] it may be assumed that they have not welcomed these new programs, and that they will attempt to undermine them through formal and informal political techniques.

The capacity of the DPH and the RSC to handle such political pressure is becoming especially important as Massachusetts attempts to move beyond these established programs to pursue a cost containment strategy that calls for "shrinking" the size of the hospital system by forcing the merger or closure of services or entire institutions. Efforts in Massachusetts to date to shrink the hospital system have been successful only when one or more of three characteristics have prevailed: (1) with respect to services, elimination of the service could perceptibly enhance the financial circumstances of the hospital, and perhaps assure a higher level of quality[26]; (2) with respect to whole institutions, the hospital's financial status has been marginal for reasons not directly related to the cost containment programs; and (3) again with respect to whole institutions, the hospital was providing care of marginal quality, and closure was possible on quality, not cost containment, grounds. Whether shrinking becomes a useful cost containment strategy[27] depends on the extent to which the state can promote the closing or partial closing of hospitals on grounds of cost savings alone, and not only in situations in which either the quality of care or the financial well-being of the hospital is already marginal. The political tasks associated with achieving such a result are made more complex because Massa-

23. *See, e.g.*, Rosenblatt, *supra* note 8, at 247-49.

24. *See* Fielding & Weiner, *Controlling Hospital Costs in Massachusetts*, 299 NEW ENGLAND J. MED. 1249 (1978); Bicknell & Van Wyck, Certificate of Need: The Massachusetts Experience, January 1974-June 1977 (1978) (copy on file in the office of the *North Carolina Law Review*). For an explicit statement on the RSC's cost containment policy, see Statement of Massachusetts Rate Setting Commission Concerning Blue Cross Participating Hospital Agreement HA-27, at 1 (November 10, 1977) [hereinafter cited as RSC HA-27 Statement (1977)].

25. Weiner, *"Reasonable Cost" Reimbursement for Inpatient Hospital Services Under Medicare and Medicaid: The Emergence of Public Control*, 3 AM. J. L. & MED. 1, 42-46 (1977).

26. *See, e.g.*, Donahue, Pettigrew, Young & Ryan, *The Closure of Maternity Services in Massachusetts: The Causes, Process, and Hospital Impact*, 50 OB. & GYN. 280 (1977).

27. Some question has been raised about the cost efficacy of mergers. *See, e.g.*, Treat, *The Performance of Merging Hospitals*, 14 MED. CARE 199 (1976).

chusetts, unlike New York,[28] has no specific statute authorizing the state to decertify facilities. The agencies in Massachusetts concerned with effectuating the "shrinkage" strategy must attempt to achieve the desired policy result using what is at best ambiguous statutory authority.[29]

Political support strategies derived from this ambiguous statutory authority may of course profit from evidence of strong political support for the DON and Chapter 409 programs themselves. Conversely, the fading of support for even such explicit programs may raise questions about the long-term political viability of the "shrinkage" strategy. In a sense, the legal authority for the implementation of "shrinkage" strategies under DON and Chapter 409 may be a matter of concern secondary to considerations of the political capacities of the respective

28. N.Y. PUB. HEALTH LAW § 2806 (McKinney 1977 & Cum. Supp. 1978).

29. The bill submitted in 1976 by Governor Michael S. Dukakis, H. No. 3160, which initiated the legislative process producing Law of Oct. 15, 1976, ch. 409, 1976 Mass. Acts 522 (codified in scattered sections of MASS. ANN. LAWS ch. 6A (Law. Co-op Cum. Supp. 1978)), contained provisions specifically incorporating into the hospital budget review process the findings from reviews of the appropriateness of institutional services undertaken by the regional and state planning agencies. *See* H. No. 3160, ch. 6A, § 38(b). Such reviews could produce recommendations for closing or merging services or entire institutions. Although the provision was not adopted, the final version of Chapter 409 does contain language that arguably could permit the RSC to incorporate appropriateness review findings into budget reviews. *See* Law of Oct. 15, 1976, ch. 409, § 5, 1976 Mass. Acts 522 (requiring adoption of a definition of "reasonable financial requirements"). *See also* Weiner, *Appropriateness Review and Rate Setting*, in PRELIMINARY APPROACHES TO APPROPRIATENESS REVIEW UNDER P.L. 93-641, at 64-67 (1978). The concept of "appropriateness review" emanates from 42 U.S.C.A. § 300*l*-2(b) (West Supp. 1979), which requires that health systems agencies undertake such reviews periodically and make findings thereon.

The potential authority in the DPH to pursue a shrinkage strategy is somewhat more speculative. Law of July 18, 1972, ch. 776, § 3, 1972 Mass. Acts 721 (codified as amended at MASS. ANN. LAWS ch. 111, § 25C (Law. Co-op 1975)) provides:

> The department, in making any such determination [of need], shall encourage appropriate allocation of private and public health care resources and the development of alternative or substitute methods of delivering health care services so that adequate health care services will be made reasonably available to every person within the commonwealth at the lowest reasonable aggregate cost.

See Interim Report of the Joint Special Committee, *supra* note 22, at 27-28. In addition, Law of July 18, 1972 established a time period within which the DPH was to "approve or disapprove, in whole or in part, *or otherwise act*" upon an application. *Id.* (emphasis added).

Relying on such language, DPH attempted to condition approvals of pending applications on consolidation or closure activities involving institutions not formally before the Department with a DON application. *See* Reeder, Mason & Glantz, *Certificate of Need: The Massachusetts Experience*, 1 AM. J. L. & MED. 13, 21-28 (1975). Because of the political response to these efforts, in 1975, the DPH adopted regulations narrowing the scope of conditions that could be attached to a determination, *see* MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH, MASSACHUSETTS DETERMINATION OF NEED REGULATIONS (November 9, 1976) [hereinafter cited as MASS. DON REGS.], and in 1977, the legislature eliminated the "or otherwise act" language. *See* MASS. ANN. LAWS ch. 111, § 25C (Law. Co-op Cum. Supp. 1978) *as amended by* Law of Jan. 9, 1978, ch. 945, § 4, 1977 Mass. Acts 1363. *See also* note 131 *infra*.

programs and the ability of the agencies administering them to withstand sustained opposition by affected segments of the hospital industry.

One vehicle available to a "reformist agency" for developing political support in this context from nonhospital interests is the provision of mechanisms for broad public participation in its policy development and decisionmaking processes. In the case of "reluctant agencies," demands by outside groups that the agency provide such mechanisms are usually intended to change the policies of the agency. In the case of "reformist agencies," on the other hand, the agency itself may wish actively to develop and indeed exploit the mechanisms for public participation to provide a means for developing or demonstrating support for the agency's policy goals. Particularly when the agency's objectives are opposed by strong and organized interests, mechanisms for public participation can significantly enhance public visibility and political support for those objectives.[30]

In considering the continuing viability of such cost containment programs as DON and Chapter 409, and the likelihood of "shrinkage" strategies being successfully implemented, a series of questions must be addressed concerning the relationships among public policy objectives, governmental process, availability of opportunities for public participation in agency decisionmaking, and the development and institutionalization of political support for reformist goals. This article will consider specifically the experiences of DON and Chapter 409 in Massachusetts; features of and lessons derived from these experiences will be of significance as governmental efforts to pursue cost containment objectives through "shrinkage" strategies intensify.

The questions considered are the following:

(1) Do the DON and Chapter 409 programs provide procedural mechanisms that facilitate participation by diverse interest groups in

30. This concept of an agency using open participatory procedures as a vehicle for developing political support is related to notions of "structural due process," which include the view that assuring adequate public participation in agency proceedings may affect substantive outcomes of agency decisions. *See generally* Rosenblatt, *supra* note 8. The present article moves somewhat beyond the case studies employed by Rosenblatt in that it assumes an affirmative willingness on the part of the regulatory agencies, DPH and RSC, to involve in their proceedings a more cross-sectional array of interest groups than ordinarily participate in regulatory procedures in order to assure that their decisions will be substantially different from those coming from "reluctant agencies." One conclusion that may be derived from the present article is that efforts to produce agency decisions conducive to the broad public interest, at least in the area of health services regulation, involve a far more complex set of tasks than even proponents of "structural due process" might suggest.

their policy formulation and decisionmaking processes and that may provide the structure for developing political support for the programs?

(2) To what extent are these mechanisms in fact used by diverse interests, particularly interests different from and perhaps opposed to the most significant adversely affected economic interests subject to the agencies' authority?

(3) If these procedural mechanisms have not assisted in producing support for the agencies' reformist objectives, what factors exist that might be constraining concerned parties from providing active support for these objectives?

(4) What strategies may be available to DPH and RSC to overcome these constraints and to permit them to develop support for their objectives? Are these strategies transferable to shrinkage objectives for which there is no explicit statutory basis?

The efforts made to answer these questions in this article are preliminary only; more analysis of the characteristics of the "reformist agency" model and more empirical research is necessary to move beyond this preliminary stage. Nevertheless, a preliminary effort to address these questions is worthwhile given the continuing discussions of cost containment strategies at the federal and state levels of government.

II. Procedural Mechanisms for Participation in Agency Decisionmaking

DPH and RSC enabling acts and regulations afford a number of opportunities for public participation in major policy activities. The devices that create these opportunities fall generally into three categories: general public notice and comment requirements applicable to proposed regulations under the state's administrative procedure act (APA)[31]; specific, statutorily established advisory or consultative processes[32]; and interventions by groups of ten or more taxpayers (ten-taxpayer interventions) in DPH review of DON applications.[33] These categories will be discussed in turn.

A. Public Notice and Comment

The Massachusetts APA establishes two major classes of regula-

31. *See* text accompanying notes 34-44 *infra*.
32. *See* text accompanying notes 41-61 *infra*.
33. *See* text accompanying notes 62-80 *infra*.

tions, those that require public hearings and those that do not.[34] A public hearing is required when such a hearing is guaranteed as a matter of constitutional right, when a statute specifically calls for one or when violation of a regulation is punishable by fine or imprisonment. Other regulations may be issued without public hearing prior to adoption.[35] In either case the agencies must provide notice of the proposed action or of the public hearing, whether the regulation is being adopted, amended or repealed, within the time specified by the relevant statute, when applicable, or at least twenty-one days prior to the action or hearing.[36] Notice must be published; it must also be filed with the Secretary of State and provided to parties who are specified in the relevant statute or who have filed annually a request with the agency to receive notice of actions with respect to proposed regulations.[37] If the proposed regulation is not one subject to a public hearing requirement, the agency shall nevertheless "afford interested persons an opportunity to present data, views or arguments in regard to the proposed action orally or in writing."[38]

With respect to either type of regulation, the agency may adopt regulations on an emergency basis without notice or a public hearing. A regulation that ordinarily requires a public hearing prior to promulgation, however, may, if issued on an emergency basis, remain in effect for no more than three months unless the agency gives notice and holds a public hearing.[39]

The APA, then, provides a basic framework within which public participation in agency rulemaking may occur. Although DPH's regulations governing the DON program are primarily procedural,[40] they do contain substantive standards and criteria that have been included in the basic regulation after public hearing.[41] RSC's responsibilities, other than under Chapter 409, must by statute be conducted in accordance with regulations "after public hearing."[42] Although a public hearing requirement is not specifically included in the provisions governing the Chapter 409 program, hospitals are subject to civil penalties for

34. MASS. ANN. LAWS ch. 30A, § 2 (Law. Co-op Cum. Supp. 1978).
35. *Id.* § 3.
36. *Id.* §§ 2 & 3.
37. *Id.*
38. *Id.* § 3.
39. *Id.* § 2.
40. *See* MASS. DON REGS., *supra* note 29.
41. *Id.* at pts. 60-65.
42. MASS. ANN. LAWS ch. 6A, § 32 (Law. Co-op Cum. Supp. 1978).

making a charge or accepting payment based on a charge in excess of that approved by the RSC, for failing to file information required by regulations of the Commission or for falsifying such information.[43] Consequently, regulations implementing Chapter 409 have been promulgated after public hearing, except when the emergency provisions have been invoked.

B. Advisory or Consultative Processes

Under its organic statute, the RSC is obliged to submit all proposed regulations, including those implementing Chapter 409, at least sixty days prior to promulgation for review and comment by the RSC's Advisory Council.[44] The Council consists of twenty-three members. Seven are state officials or their designees, serving *ex officio*.[45] The remaining sixteen members are appointed by the Commission. Eight are to be "providers, or representatives of provider organizations, whose rates of reimbursement are determined by the commission," and eight are to be "non-providers who have demonstrated experience in the field of consumer advocacy and who have no financial interest in any provider of services whose rates of reimbursement are determined by the commission."[46]

Some additional requirements pertain to the provider and the nonprovider categories. No provider group may have more than one representative on the Council unless all provider groups or classes are already represented.[47] Since the RSC establishes rates for more than eight provider groups,[48] the RSC in fact must decide which provider groups *will not* be represented on the Council at any one time.[49] Further, within the nonprovider category, two of the eight must be selected

43. *Id.* § 44.
44. *Id.* § 34.
45. *Id.*
46. *Id.*
47. *Id.*
48. *Id.* § 32 provides that the RSC shall have sole responsibility for establishing "rates to be paid providers of health care services by governmental units, including the division of industrial accidents in the department of labor and industries," and for establishing charges "to be used by state institutions for general health supplies, care, social, rehabilitative or educational services and accommodations." Under this authority the RSC establishes rates or charges for hospitals, skilled nursing facilities, intermediate care facilities, rest homes, physicians, dentists, pharmacists, podiatrists, psychologists, home health agencies, neighborhood health centers, day-care centers, group residence facilities for juvenile offenders, occupational, physical and speech therapists, state public and mental health hospitals and state schools for the retarded, as well as other providers of health rehabilitation and social services.
49. In its first appointment to the Council, the RSC named representatives for the following provider classes: hospitals, long-term care facilities, physicians, pharmacists, home health agen-

from recommendations "by state-wide organizations representing the interests of the elderly," and two from recommendations of statewide labor organizations, with one of the two selected specifically from recommendations of the State Labor Council, AFL-CIO.[50]

The RSC Advisory Council is entitled to sixty days to review and comment on all regulations proposed by the RSC prior to promulgation. It is to receive ten days advance notice of any public meeting or hearing scheduled by the RSC or one of its bureaus.[51] Other rights and responsibilities are more generally stated: it "shall advise on the overall operation and policy of the commission and its bureaus, [and] shall consider any item recommended by the commission, the chairman of the council, a majority of the council members or by a subcommittee."[52] The enabling act envisions that much of the work of the Advisory Council will be conducted by subcommittees created to correspond directly to the operating bureaus of the RSC, perhaps as a device for developing enhanced expertise and producing more immediate impact on early stages of the process of identifying issues for subsequent policy development.

With respect only to the Chapter 409 program, the statute provides for two review processes in addition to that assigned the Advisory Council. First, in developing regulations governing review of applications for charge modifications submitted by hospitals, the RSC must consult with representatives of Blue Cross of Massachusetts, Inc., the Massachusetts Hospital Association, commercial insurance carriers, and the health systems agencies.[53] Similar consultations are mandated before the RSC may adopt a methodology for grouping hospitals and undertaking cost comparisons in approving hospital budgets.[54] Such consultations are required even if the regulations are promulgated on an emergency basis.

The second review process established by Chapter 409 is carried out by yet another advisory group, the Hospital Policy Review Board.[55] Unlike the Advisory Council, the Policy Review Board's responsibili-

cies, neighborhood health centers, day-care centers and group residential treatment facilities. RSC Advisory Council files.

50. MASS. ANN. LAWS ch. 6A, § 34 (Law. Co-op Cum. Supp. 1978).

51. The specification of Advisory Council rights is derived from *id.*

52. *Id.* The Chairman of the Advisory Council is to be selected annually from among its non-provider members. *Id.*

53. *Id.* § 37.

54. *Id.* § 40.

55. *Id.* § 34A.

ties are limited to overseeing the RSC's implementation of Chapter 409 alone, and its membership is established not to represent state, provider, and nonprovider interests generally, but to offer a forum for identified interests concerned about or affected by the administration of that program—specifically, hospitals, physicians, health systems agencies, Blue Cross, commercial insurance carriers, business, labor, and the elderly.[56] Unlike the nonprovider members of the Advisory Council, who are expected to be experienced in consumer advocacy, the Policy Board's nonprovider members are expected to have technical proficiency in matters pertaining to hospital service delivery or financing.[57]

The rights and responsibilities of the Policy Board are more extensive than those of the Advisory Council. It also is entitled to a sixty-day review and comment period with respect to proposed regulations implementing Chapter 409,[58] but it has the right to more information than merely the language of the proposed regulations themselves, because the RSC must issue an explanatory statement accompanying the proposed regulations.[59] Unlike the Advisory Council, the Policy Board is obliged to submit written comments on all proposed regulations, recommending approval, disapproval, or partial approval. If the RSC does not accept a recommendation, it must provide the Board with a written statement of its reasons for disagreement. Both the Board's recommendation and the RSC's statement become part of the record of any public hearing held on the proposed regulation. Further, if the Board has recommended against promulgation of a regulation, the RSC must delay promulgation for at least twenty-one days to provide the Board an opportunity to hold a public hearing on the recommendations.

Three additional rights of the Board are significant in determining its relationship to the RSC. First, individual Board members are entitled by statute not merely to present evidence at public hearings held by the RSC on proposed Chapter 409 regulations, but to present wit-

56. *Id.*

57. *Id.*

58. The rights and responsibilities of the Policy Review Board specified in this and the next paragraphs of the text are derived from *id.*

59. There has as yet been no judicial determination with respect to the content or level of detail expected to be included in the explanatory statement. Query whether judicial interpretation of the Administrative Procedure Act, 5 U.S.C. § 553(c) (1977), that an agency "shall incorporate in the rules adopted a concise general statement of their basis and purpose," would be applicble to the RSC's responsibility to provide an explanatory statement. *See, e.g.*, Amoco Oil Co. v. EPA, 501 F.2d 722 (D.C. Cir. 1974); Kennecott Copper Corp. v. EPA, 462 F.2d 846 (D.C. Cir. 1972).

nesses as well. Second, if four members of the Board (less than a standard quorum) so request, the Board is to hold a public hearing on its own with respect to the RSC's policies and activities carried out under Chapter 409. Finally, the Board is required to report at least annually to the governor and the legislature on its findings, opinions and recommendations for legislation, and copies of this report must be sent to the Joint Legislative Committee on Health Care.

In summary, Chapter 409 provides for consultation with a cross-section of affected interests on the issuance of all regulations, including emergency regulations, and provides further that in issuing final regulations under the program, the RSC must undergo three separate review and comment processes involving a potentially very broad range of interests. These three sets of review procedures are separate and distinct from the required notice and comment procedure under the APA. Finally, at least one of the review processes, that undertaken by the Hospital Policy Review Board, involves technically expert parties and requires a clear explication on the part of the RSC of the policy objectives associated with its implementation of Chapter 409.

The DPH, in promulgating DON regulations, is not required to undergo consultative or review and comment processes similar to those applicable to Chapter 409. The DON statute does, however, provide for participation in the DON rulemaking process by health systems agencies (HSAs), the regional planning agencies established under the National Health Planning and Resources Development Act of 1974.[60] The participation rights of the HSAs are virtually identical to those of the ten-taxpayer groups described below.[61] The potential significance of the HSAs in the DON rulemaking process is also discussed in Part V below.

C. Ten-Taxpayer Interventions

The Massachusetts DON statute authorizes formal participation in the regulatory process by a ten-taxpayer group. Specifically, any such group may request a public hearing on a DON application,[62] and, if aggrieved by the DPH determination, may file an appeal with the Health Facilities Appeals Board.[63] In addition, a ten-taxpayer group

60. 42 U.S.C.A. §§ 300*l*-1 to 300*l*-2 (West Supp. 1979).

61. *See* text accompanying notes 62-80 *infra*.

62. MASS. ANN. LAWS ch. 111, § 25C (Law. Co-op 1975 & Cum. Supp. 1978).

63. *Id.* § 25E (Law. Co-op 1975). The Health Facilities Appeals Board is established under *id.* ch. 6, § 166, as the administrative appellate body for determinations of need made by the DPH

can go to court to enforce the provisions of the Act.[64]

While the vehicle of ten-taxpayer interventions has been used by very diverse interests,[65] the statutory provision was probably intended primarily to enhance "consumer" participation in the DON process.[66] Its underlying policy appears to address the need to inform consumers, who then can play an effective role in decisions affecting the health care delivery system. The statute's effort to increase consumer involvement and responsibility is reflected in the composition of the Health Facilities Appeals Board[67] and in the Act's restructuring of the governing body of the DPH, the Public Health Council, from a physician majority to a nonprovider majority.[68]

DPH regulations implementing the DON program have provided procedural rights to ten-taxpayer groups[69] beyond those contained in the statute. These are:

(1) Even if a ten-taxpayer group does not request a public hearing, it is afforded a reasonable opportunity to comment on a DON application. DPH is required to consider such comments, if filed in a timely and proper manner, before acting on the application.[70]

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under *id.* ch. 111, § 25C (Law. Co-op 1975 & Cum. Supp. 1978). The Board consists of a majority of nonproviders. Its scope of review and procedures with respect to departmental determinations is set forth at *id.* § 25E (Law. Co-op 1975).

64. *Id.* § 25G (Law. Co-op 1975). Although there is no specific provision in the statute for a ten-taxpayer group to seek review of a decision by the Health Facilities Appeals Board, *id.* § 25E provides for judicial review of "final decisions" of the Board under the provisions of *id.* ch. 30A, § 14 (Law. Co-op 1973 & 1978 Cum. Supp.), except to the extent the provisions of that section are inconsistent with the provisions of *id.* ch. 111, § 25E (Law. Co-op. 1975). *Id.* ch. 30A, § 14 (Law. Co-op 1973 & 1978 Cum. Supp.) provides for standing to seek judicial review of final agency decisions by "any person . . . aggrieved by" such decisions. While it would be possible to argue that ten-taxpayer groups with standing to appeal to the Health Facilities Board constitute ten taxpayers aggrieved by adverse final decisions of the Board, a superior court has found that ten taxpayers comprising an intervening group are not "persons aggrieved" within the meaning of the statute. Shoolman v. Health Facilities Appeals Board, No. 30373 (Super. Ct., Suffolk Cty., Mass. June 1, 1979).

65. *See* text accompanying notes 97-110 *infra.*

66. Interim Report of the Joint Special Committee, *supra* note 22, at 40.

67. *See* note 63 *supra.*

68. MASS. ANN. LAWS ch. 17, § 3 (Law. Co-op Cum. Supp. 1978) provides that the Public Health Council shall consist of the Commissioner of Public Health as Chairman and eight members appointed by the Governor, three of whom shall be providers of health services and five of whom shall be "nonproviders," a term defined in the same section. Prior to 1972, the Council consisted of the Commissioner and six appointed members, of whom three were to be physicians, and until 1975, Massachusetts law required that the Commissioner be a physician. Law of July 7, 1914, ch. 972, § 3, 1914 Mass. Acts 970. The statute now permits a non-physician to serve in the position. MASS. ANN. LAWS ch. 17, § 2 (Law. Co-op Cum. Supp. 1978).

69. MASS. DON REGS., *supra* note 29, § 14, establishes a procedure by which a ten-taxpayer group may duly register with the DPH in order to be assured of the participation rights described in the text accompanying notes 70-80 *infra.*

70. MASS. DON REGS., *supra* note 29, §§ 40.1 & 43.

(2) Comments on hospital applications by appropriate HSAs, the state comprehensive health planning agency, and, when relevant, the Departments of Elder Affairs or Mental Health, are to be submitted to all duly registered ten-taxpayer groups.[71]

(3) If DPH's staff prepares a report on an application that rejects specific recommendations submitted in writing by a ten-taxpayer group, the staff report is to be available in the Department's public file for at least twenty-one days before the DPH meeting scheduled to consider the application,[72] and a copy of the staff report is to be mailed to any affected, duly registered ten-taxpayer group.[73]

(4) If the staff report rejects a specific recommendation contained in the written comments of a ten-taxpayer group, the group has the right to respond in writing to the Department, provided certain procedural requirements are satisfied.[74] The group's written response is specifically included in the documentation presented to the Public Health Council when it considers an application.[75]

(5) The Commissioner of Public Health is required to establish the agenda of applications to be considered by the Public Health Council at least seven days prior to its scheduled meeting. No additional applications may then be included on the agenda without the consent of interested parties, including any intervening ten-taxpayer group. At least five days before the scheduled meeting, the Commissioner must provide oral or written notice of the agenda to affected ten-taxpayer groups.[76] An applicant may request postponement of consideration of his application, but a request is not to be granted if the Commissioner determines that it would prejudice, among others, an affected ten-taxpayer group.[77] A ten-taxpayer group can itself request postponement, but the regulations indicate that "said request will rarely be granted." Exceptions to this general rule may occur when the Commissioner determines that the request is for good cause and that failure to grant the request will "significantly prejudice the party making the request from having its position considered by the Council."[78]

71. *Id.* § 42.5.

72. *Id.* § 44.3(2). If there is no disagreement between DPH staff and the ten-taxpayer group, the staff report need be in the public file for only seven days. *Id.* § 44.3(1).

73. *Id.* § 44.3(2).

74. *Id.* § 44.4.

75. *Id.*

76. *Id.* § 51.2.

77. *Id.* § 51.3.

78. *Id.*

(6) When an application generates conflicting positions, affected ten-taxpayer groups may make oral presentations to the Council during the meeting at which the application is considered.[79]

Enumeration of these additional rights conferred on ten-taxpayer groups reveals that the regulations go well beyond the skeletal language of the statute to provide possibilities for organized ten-taxpayer groups to have their views heard during departmental deliberations on DON applications.[80]

III. Efficacy of Public Participation Opportunities in Supporting Program Objectives

The preceding descriptions suggest that statutes or regulations governing operation of the two major cost containment programs in Massachusetts provide substantial opportunity for members of the general public and representatives of nonprovider interest groups to participate in agency proceedings. Indeed in some cases they are able to require the agency to explain its positions or policies that are not consistent with the views of the particular outside interest.

There is no sound methodology to determine whether the "reformist" RSC and DPH have made use of public participation through these devices to develop a political constituency for or general public support of the agencies' decisions. Two types of analysis, however, would indicate whether there is a relationship between the availability of such devices and general support for the cost containment objectives of the DON and Chapter 409 programs. The first is an examination of actual participation in and use of the processes.[81] The second is a determination of the extent to which, despite the opportunities for public participation, external political opposition to the program has developed and had an impact on the program's operation.[82] Some preliminary information is available for these analyses with respect to Chapter 409 and DON. The information suggests that constructive use of the procedures occurs only in limited situations, and that the availability of the

79. *Id.* § 51.6. The hearing before the Council is not an adjudicatory hearing. *Id.* § 51.1. Therefore, formal cross-examination would ordinarily not occur.

80. *See* text accompanying notes 62-68 *supra.*

81. *See* text accompanying notes 83-110 *infra.*

82. Successful opposition to a cost containment program, as represented, for example, by the legislative overrides of DPH decisions under the DON program, *see* text accompanying notes 111-30 *infra*, may indicate lack of potential support for the program's objectives. On the other hand, the absence of political efforts to undercut a program's efficacy may suggest nothing more than the program's ineffectiveness. See text accompanying notes 128-59 *infra*, for discussion of why there has been little political opposition to administration of the Chapter 409 program.

procedural devices does not necessarily protect the program from effective political opposition.

A. Use of Established Procedural Devices

1. Public Notice and Comment

The devices for public participation in the regulation issuance process have been used relatively infrequently in implementing DON because the regulations that have been issued are primarily procedural. The incorporation of substantive standards and criteria into these regulations generally follows a two-step process. The first is a so-called "generic" process involving widespread consultation among a diverse group of interests outside of any formal procedural structure.[83] Ultimately, the results of such an informal consultative process are formulated into proposed regulations processed pursuant to APA requirements. The informal process is significant, and its implications are explored in somewhat greater detail below.[84] The informal process, of course, does not entail the right of participation, which is a feature of the formal procedural devices discussed earlier.

The RSC promulgates regulations governing administration of Chapter 409 at least annually. No specific interest groups are required to participate in the public notice and comment process, and anyone from the general public may, under agency practice, testify at public hearings or submit written comments into the record of the proceeding. Since the inception of the Chapter 409 program,[85] nine public hearings have been held on implementing regulations.[86] All but two of the public hearings consisted exclusively of testimony submitted by RSC staff, hospital representatives, or spokesmen for the Massachusetts Society of Certified Public Accountants, the members of which are responsible for preparing financial information for hospitals. The only other group to be represented at any of the hearings has been the Massachusetts Con-

83. For a description of this process, see MASSACHUSETTS DEP'T OF PUBLIC HEALTH, DRAFT STATE HEALTH PLAN §§ 1.15-1.16 (1978). *See also* Feeley & Feldman, Certificate of Need Regulations, pts. A, C (undated draft prepared for Executive Programs in Health Policy, Planning and Regulation, Harvard School of Public Health).

84. *See* text accompanying notes 211-220 *infra*.

85. For purposes of this discussion, the Chapter 409 program encompasses not only the program established by Law of Oct. 15, 1976, ch. 409, 1976 Mass. Acts 522 (codified in scattered sections of MASS. ANN. LAWS ch. 6A (Law. Co-op Cum. Supp. 1978)), but also the predecessor interim program established by Law of July 9, 1975, ch. 424, 1975 Mass. Acts 449.

86. Below is a listing of the proposed implementation regulations and hearing dates for both the Chapter 409 program and the predecessor interim program established under Law of July 9, 1975, ch. 424, 1975 Mass. Acts 449 through June 1979:

sumer Council, a state agency responsible for advocating consumer interests generally,[87] and Blue Cross of Massachusetts, Inc.

This lack of general public participation at the hearings may be explained in part by the highly technical nature of the material included in the regulations. The RSC employs a formula approach[88] to develop allowable cost, revenue, and charges; accordingly, many of its regulations are devoted to such mathematical constructs as the methodology for calculating cost increases due to inflation in the economy generally[89] or net increases in the volume of services the hospital provides.[90] While each of the technical features of such a regulation reflects potentially significant policy decisions, an adequate understanding of the implications of these decisions, because of the technical nature of the materials, is generally beyond the capacity of most persons not trained in the relatively new techniques of rate regulation. Expertise, at least currently, is limited to agency staff, the providers, and some of the groups represented on the Hospital Policy Review Board. Indeed, it may very well be that the lack of participation at Chapter 409 public hearings is a result of the availability of the Hospital Policy Review Board and the consultative processes under Chapter 409 as the focus for participation by those parties that already possess sufficient technical proficiency to understand the intricacies of the proposed reg-

Proposed Regulation	Hearing Date	Legislative Authority
14 CHSR 4	October 3, 1975	Law of July 9, 1975, ch. 424, 1975 Mass. Acts 449
14 CHSR 4	March 16, 1976	*Id.*
14 CHSR 4	April 27, 1976	*Id.*
14 CHSR 9	January 10, 17, 1977	Law of Oct. 15, 1976, ch. 409, 1976 Mass. Acts 522
14 CHSR 9	March 21, 1977	*Id.*
114.1 CMR 4.00	April 18, 1978	*Id.*
114.1 CMR 8.00	August 9, 1978	*Id.*
114.1 CMR 8.00*	October 27, 1978	*Id.*
114.1 CMR 8.00*	January 24, 1979	*Id.*

* Amendments only

87. The Council is established under MASS. ANN. LAWS ch. 6, § 115 (Law. Co-op 1973). Among its responsibilities is that of informing the public, "through appearances before . . . state . . . commission . . . hearings . . . , of such policies [and] decisions . . . as are beneficial or detrimental to consumers." Its membership consists of the Attorney General, the Chairman of the Department of Public Utilities, the Commissioners of Banks, Insurance, and Labor and Industries, *ex officiis*, and eight members appointed by the Governor, of whom one is to be a member of the State Labor Council, AFL-CIO. *Id.*

88. For a general discussion of different approaches to ratesetting, see Bauer, *Hospital Rate Setting—This Way to Salvation?*, 59 MILBANK MEM. FUND Q. 117 (1977).

89. *See, e.g.*, Massachusetts Rate Setting Commission Regulation, 114.1 C.M.R. § 8.11 (1978).

90. *Id.* at 8.12-13.

ulations. Less knowledgeable members of the general public may be constrained by the existence of such mechanisms merely to state support for the general approach of the RSC (to the extent that it may be gleaned from the regulations) or not to participate in the process, with the expectation that more expert parties can capably represent their interests.[91]

Whatever the explanation, the availability of public hearings prior to promulgating Chapter 409 regulations has not served to provide the RSC with diverse views, separate from any analyses undertaken by the Hospital Policy Review Board, nor has it therefore enabled the agency to create a general public understanding of its processes and policy objectives.

2. Advisory Council and Review Board

There have been significant differences in the roles played by the RSC Advisory Council and the Hospital Policy Review Board established under Chapter 409.[92] The Advisory Council had nine vacancies as of January 1, 1979: one in the nonprovider labor category, three in the general nonprovider category and five in the provider category. The only provider groups represented on the Council as of that date were physicians, residential child care programs and day-care services. The Council had not met as a formal body with a quorum present since November 14, 1977. It has never submitted any formal written comments on any proposed RSC regulation, nor has it submitted even informal comments on proposed Chapter 409 regulations.

In contrast, as of January 1, 1979, the Hospital Policy Review Board had met twenty-one times since its formation in February 1977. As required by statute, it had made formal recommendations to the RSC on all proposed Chapter 409 regulations. In a number of instances, it has recommended changes, the substance of which has on all of these occasions been incorporated into the regulations ultimately promulgated. It is significant that the Board generally supports the policies of the RSC and that, when there has been specific disagreement, the RSC has generally accepted the Board's recommendations as being

91. Such an attitude raises the distinct possibility that the administrative agency itself will increasingly assume that it can discern the public interest without the necessity of participation by diverse groups representing different perspectives. For an expression of concern about administrative agencies assuming this responsibility, see Office of Communications of the United Church of Christ v. FCC, 359 F.2d 994 (D.C. Cir. 1966).

92. For a description of these bodies, see text accompanying notes 44-58 *supra*. The details concerning meetings and actions of the two bodies are derived from RSC files.

consistent with the objectives of the agency.[93]

Differences in the composition, rights and responsibilities of the two advisory groups may account for some of these differences in performance. First, the members of the Board are statutorily specified to include the major interest groups that are concerned about and affected by the Chapter 409 program, and some level of technical proficiency in ratesetting issues is either assumed or required.[94] In contrast, the Advisory Council consists of persons drawn from very diverse interest backgrounds. Their capacity to concentrate on any one set of issues is limited, for example, by the requirement that no more than one member represent any one provider group. There is no established necessity for expertise in ratesetting matters.[95]

Second, the Advisory Council is expected to review all ratesetting regulations, which cover an extensive set of health providers, institutional and noninstitutional, as well as social and educational, service providers. Since the agency issues numerous regulations annually,[96] it is difficult for the Council to focus consistently on a specific set of policy issues. The Board, on the other hand, considers only one program, can follow its evolution sequentially and can develop a level of sophistication concerning policy choices based on a consistent and continuous familiarity with the program as it unfolds.

Third, the Board's statutory right to demand explanations from the agency when policy differences emerge, and to delay somewhat promulgation of regulations, enables the Board to be a "presence" in agency decisions. If major disputes develop, the Board may initiate its own public hearings and may report its views directly and officially to the governor and to the legislature. These rights, coupled with the expertise possessed by individual Board members, make it a serious force

93. A major policy dispute emerged between the RSC and a majority of Hospital Policy Review Board members with respect to the changes required by Chapter 409 to be implemented by October 1, 1978. *See* text accompanying notes 152-154 *infra*. The RSC adopted a position closer to that of the Board majority. The resulting proposed amendments to 114.1 CMR 8.00 were the subject of a public hearing held on October 27, 1978.

94. MASS. ANN. LAWS ch. 6A, § 34A (Law. Co-op Cum. Supp. 1978) requires that the nonprovider members of the Board have "experience in or knowledge of the delivery or financing of hospital services."

95. *Id.* § 34 requires that nonprovider members of the Council be persons "who have demonstrated experience in the field of consumer advocacy and who have no financial interest in any provider of services whose rates of reimbursement are determined by the commission."

96. For example, in fiscal year 1976 (July 1, 1975 - June 30, 1976), the RSC issued 39 regulations, including amendments and emergency regulations. COMMONWEALTH OF MASSACHUSETTS RATE SETTING COMMISSION, ANNUAL REPORT FOR FISCAL YEAR 1976, at 62-65 (1977). In fiscal year 1977, the number was 14. COMMONWEALTH OF MASSACHUSETTS RATE SETTING COMMISSION, ANNUAL REPORT FOR FISCAL YEAR 1977, at 56-57 (1978).

that must be given due weight by the RSC in deciding on the content of Chapter 409 regulations.

3. Ten-Taxpayer Interventions

The right of ten-taxpayer groups to participate in the processing of DON applications has been invoked with some frequency. During the period January 1974 through June 1977, one or more ten-taxpayer groups participated in 63 of the 517 DON project applications, a participation rate of 12.2%.[97] Of the total number of projects processed during this period, 226 were based on hospital applications,[98] and of those, 29, or 12.8%, involved ten-taxpayer group participation.[99]

A recent analysis of the Massachusetts DON experience concludes with respect to ten-taxpayer group interventions, that "more often than not ten-taxpayer groups are directly or indirectly convened, supported and organized by providers to support their own applications or by competing or potentially competing applicants."[100] One of the authors of this study, a former Commissioner of DPH, opined that "no more than half a dozen ten taxpayer groups could reasonably be conceived of as representing consumer and broad community interests"[101] during the period he served as Commissioner.

Analysis of the participation of ten-taxpayer groups in all DON project applications (not only hospital applications) since 1974 suggests a more discrete classification of the groups.[102] It appears that ten-taxpayer interventions fall into four primary categories:

(a) Ad Hoc Groups. Of the 260 ten-taxpayer groups participating in the period under study, 89, or 34.2%, were considered as falling into the ad hoc category. These are groups formed by individuals without evident institutional ties or financial involvement with the applicant or competing applicants. Generally, the position of such groups is negative: many were formed, for example, to oppose half-way houses or abortion clinics in their neighborhoods. Those groups intervening in

97. Bicknell & Van Wyck, *supra* note 24, at 57.

98. *Id.*

99. *Id.*

100. *Id.* at 54.

101. *Id.*

102. The analysis of ten-taxpayer interventions at the DPH proceedings level is based on an examination of DON files undertaken by Thomas Lewis, J.D., staff attorney at the Center for Law and Health Sciences, Boston University School of Law. The typology used in the text was devised by Mr. Lewis. A detailed report on Mr. Lewis' analysis of the ten-taxpayer group intervention in DPH proceedings is to appear in *The American Journal of Law and Medicine.*

DON applications for hospital projects evidenced concern about the impact on the local community of proposed major building projects.

These groups tend to evolve spontaneously with single issue concerns. Because of their genesis, they do not develop technical sophistication in the substance or law relating to DON and ordinarily are not able to develop and maintain positions that provide assistance to the DPH staff or the Public Health Council in arriving at decisions based on the application of general policies. They are not concerned with the broader policy objectives of the DPH or the DON process, although they may employ the terminology of cost containment to support their single issue objectives.

The ad hoc groups do, however, represent legitimate grass-root concerns and may be viewed as reflecting general community interests in particular applications. While, therefore, their participation in DON appears to be consistent with the original purpose of including ten-taxpayer group intervention rights in the statute,[103] ad hoc groups cannot be viewed as providing a natural constituency for the cost containment objectives of DON. Indeed, their support of the program's objectives is presumably no greater than the DPH's willingness to support their opinions about a particular project application.

(b) Community Organizations. These ten-taxpayer groups arise from already established community organizations and therefore approach the specific issues involved in a DON project application from the perspective of the parent group's broader community objectives. It is estimated that about 23 of the 260 ten-taxpayer group interventions, or 8.8%, during the period under study were in this category. Most of these groups, because of their on-going character, have acquired a degree of expertise in dealing with governmental agencies generally not possessed by ad hoc groups. Moreover, many have legal representation. Consequently, the points they raise tend to be tailored to the DON process. These groups also have sufficient sophistication to appreciate the necessity of developing arguments invoking issues of cost-effectiveness, adequacy of planning and avoidance of duplication of facilities or services. Ordinarily, such groups will play on the Public Health Council's emphasis on community participation by alleging inadequate consultation between the applicant and the group's parent organization. In a number of cases, this has led to a delay in the processing of the application pending such consultation.

103. *See* text accompanying note 66 *supra.*

It appears, however, that ten-taxpayer groups in this category may often use a DON application to support objectives unrelated to the purposes of the application itself. For example, a Community Action Program established a ten-taxpayer intervention in the application process of a local hospital seeking to purchase a radiotherapy simulator and to renovate its radiology unit. The group alleged inadequate consultation by the hospital with the community's poor and Hispanic populations. By virtue of the intervention, the group obtained the hospital's agreement to extend outreach programs to those populations, as well as to publicize the availability of free care pursuant to Hill-Burton program requirements. While the group's objectives were valuable, and certainly reflected the needs and desires of a significant segment of the local community, once these specific objectives were obtained, the group dropped its objections and endorsed the hospital's application.[104]

Community organizations, then, have developed skills in using the available statutory machinery to further their specific objectives. Not only are these objectives not intended to effectuate any cost containment policies inherent in DON, but to the extent they involve efforts to extend hospital services, they may be cost-producing.[105] As noted above with respect to the ad hoc groups, the community organizations do reflect "grass-roots" and public interest concerns, but because of the specificity of their objectives in intervening in the DON process, they do not provide a natural constituency to further general support for the program.

(c) Financially Self-Interested Groups. A number of groups intervene because they have direct financial stakes in the outcome of the review process. If approval were to be granted, they would suffer an economic harm. Ordinarily, these groups retain counsel and invoke considerations of cost-effectiveness and health planning to further their point of view. Rarely do they make a clear and direct statement of their financial interest, but their interest is usually perceived during the course of the application process.[106] Only 5 of 260 interventions, or

104. *See* DPH DON files, Application of Salem Hospital, No. 6-2646, and intervention of North Shore Community Action Program. *See also* Application of Lawrence General Hospital, No. 3-2647, and intervention of ten-taxpayer group chaired by Isabel Melendez.

105. In Application of Salem Hospital, No. 6-2646, the Hospital agreed to develop community outreach programs. In Application of Lawrence General Hospital, the Hospital agreed to establish a primary care clinic for the community.

106. A rare example of an explicit statement of financial self-interest on the part of an intervening ten-taxpayer group occurred with respect to the application of the Massachusetts General Hospital to build an Ambulatory Care Center; No. 6-2434. Many MGH physicians, who would

1.9%, during the period of the study, can reliably be categorized as involving financially self-interested groups.

(d) Institutional "Front" Groups. While it is difficult precisely to identify them as such, a number of groups appear to be fostered by the applicant institution specifically for purposes of supporting the application. When the subject matter of the application has no direct impact on the delivery of health care, for example, a request to acquire new research equipment, it may be presumed that intervening groups have been developed by the institution. In at least one case, a ten-taxpayer group used stationery that bore the name of the hospital whose application it was supporting.[107] For the period under study, 142 of the 260 interventions, or 54.6%, have been, somewhat arbitrarily, included within this category. Of the 142, however, 135, or 52% of all ten-taxpayer interventions, were by groups formed to support a single project, a proposed parking garage.[108]

A review of the categorization and intervention objectives of ten-taxpayer groups suggests that they have been used largely to pursue particular community or local interests. Only rarely, if at all, have they attempted to further a general public interest in facility planning or cost containment. Because of the defined interest for which each intervenes, none of the categories of the ten-taxpayer groups represents a stable constituency available to the DPH in support of general program objectives, nor is any one of them therefore likely to have an impact on the broad goals or structure of DON, as opposed to the impact they can be expected to have on features of outcomes of specific applications. While, therefore, the perceived statutory objective of an enhanced "consumer" or "public" role[109] has been served by the availability of this mechanism, it appears to have had only a marginal impact on attaining general DON program objectives. As with participation in RSC public hearings, one of the reasons for less informed and con-

move into the proposed facility if constructed, were renting office space from an adjoining office and residential complex, the Charles River Park. The developer of the Park formed an intervening group, the Charles River Park Group. DPH's file on the application contains a letter of October 2, 1975 from the Group's attorney, who stated that "Charles River Park first became involved . . . out of substantial concerns for . . . loss of tenants from its professional office space." The Group, however, argued against the application on the basis of cost-effectiveness.

107. *See* DPH DON files, Intervention of Chelsea-Revere-East Boston-Winthrop Task Force, George Tyson, Chairman, in Application of Massachusetts General Hospital-Chelsea Health Center, No. 4-2657.

108. *See* DPH DON files, Application of Winchester Hospital, No. 3-2548. The transcript of the PHC meeting on this application, held February 24, 1976, noted that there were 135 groups intervening in support, but no addresses were provided.

109. *See* text accompanying notes 66 & 103 *supra.*

structive use of the ten-taxpayer interventions may derive from the availability of other mechanisms to provide DPH with more "expert" information, specifically the statutory right of participation by HSAs.[110] Although no systematic study has yet been undertaken of the role of HSAs in the DON process in Massachusetts, one can reasonably speculate that many of the persons technically knowledgeable about the operations and objectives of the DON program, and sympathetic to its health planning and system restructuring goals, are likely to participate in the HSA review and comment process.

B. Political Opposition to Cost Containment Programs

Another method for determining whether provisions for public participation have produced general support for the objectives of DON and Chapter 409 involves consideration of the political opposition to the programs, that is, the extent to which such political opposition has developed, and its effectiveness in undercutting program objectives or decisions. While political opposition may take many forms, one of the most dramatic and most likely to be effective is a legislative effort to modify or override the program. When opposition reaches the level of affirmative legislative action to intervene, it may be presumed that disaffection with the program is extensive and that the program has not been able to develop countervailing political support. Analysis of legislative responses to the cost containment programs reveals clear differences between DON and Chapter 409.

The original DON legislation in Massachusetts derived from competing bills initially submitted by the governor and the Massachusetts Hospital Association.[111] At a point in the legislative process when it was felt that no bill would be enacted, however, a legislative committee produced its own version and ushered it to enactment as an emergency act.[112] A special legislative committee was then authorized to develop permanent legislation, and the DON bill finally enacted was almost entirely a product of that committee.[113] Thus, both the decision to en-

110. *See* MASS. ANN. LAWS ch. 111, §§ 25C, E, G (Law. Co-op 1975).

111. *See* Commonwealth of Massachusetts, General Court, S. Docs. 1016 and 1453; H. Doc. 6125 (1971). *See also* Interim Report of the Joint Special Committee, *supra* note 22, at 3.

112. Law of Nov. 15, 1971, ch. 1080, 1971 Mass. Acts 1074. *See* Interim Report of the Joint Special Committee, *supra* note 22, at 3.

113. *See generally* Interim Report of the Joint Special Committee, *supra* note 22. Certain amendments were added to the Committee's proposal by the House and some were incorporated into the final Conference Committee version of the bill, which became Law of July 18, 1972, ch. 776, 1972 Mass. Acts 721. The amendments, however, did not go to the scope of the program, but

act a DON program and the structure of the program may be considered results of legislative, not executive or nongovernmental, initiative. It would therefore be reasonable to expect strong legislative support for the program.

This initial legislative support for the program did not, however, prevent the legislature on five occasions through the 1977 session from passing special bills for the purpose of overriding DPH decisions unfavorable to applicant hospitals. All five bills were vetoed by the governor, but all but one of the vetoes were overridden.[114] Three of the bills ultimately enacted over the governor's veto affected relatively small institutions with strong community ties.[115] Indeed, two of the three were municipally owned.[116] It may be inferred that in all three cases it was a matter of political significance to the local representatives and senators that the affected hospital be supported, and that members of the legislature responded to this situation of political necessity with empathy. The fourth bill enacted over the governor's veto supported a Catholic institution, was endorsed by the Archidocese, and was, not surprisingly, approved by a strongly Catholic legislature.

The only one of these bills not ultimately enacted related to the New England Baptist Hospital, a teaching hospital in Boston with no particularly strong ties to the local community. The proposed project was also the largest of the five in dollar terms. The absence of an organized constituency in the community to support the hospital, coupled with the magnitude of the project, permitted discussion to focus primarily on the cost implication of the special bill, not on community pride or other such factors.[117]

The validity of these statutory overrides of specific DON decisions by DPH was the subject of an action for declaratory judgment brought

related primarily to the DPH's capacity to assess application fees, the organizational structure of the Public Health Council, and the scope of review of the Health Facilities Appeals Board.

114. *See* Law of Oct. 17, 1973, ch. 923, 1973 Mass. Acts 935 (Bessie M. Burke Memorial Hospital); Law of Nov. 19, 1973, ch. 1053, 1973 Mass. Acts 1092 (Winchendon Hospital); Law of Nov. 9, 1977, ch. 721, 1977 Mass. Acts 873 (Amesbury Hospital); Law of Jan. 3, 1978, ch. 907, 1977 Mass. Acts 1262 (St. John of God Hospital); House Doc. 2960 (1977) (New England Baptist Hospital) (passed by both Houses but vetoed by Governor; veto sustained). *See also* Law of July 22, 1974, ch. 583, 1974 Mass. Acts 561 (Bessie M. Burke Memorial Hospital).

115. The institutions affected were Bessie M. Burke Memorial Hospital, Winchendon Hospital and Amesbury Hospital.

116. The institutions were Bessie M. Burke Memorial Hospital (Lawrence) and Amesbury Hospital (Amesbury).

117. *See* BOSTON GLOBE, Jan. 31, 1979, at 1, col. 1; *id.*, Jan. 9, 1978, at 12, col. 1; *id.*, Dec. 18, 1977, at 6, col. 1 (criticizing special bills, particularly one approving a $30 million project for the New England Baptist Hospital, for undermining the state's cost control efforts).

by the Commissioner of Public Health. In that suit, *Commissioner of Public Health v. Bessie M. Burke Memorial Hospital*,[118] the Commissioner alleged that the legislative actions constituted violations of articles 10 and 30 of the Declaration of Rights of the Massachusetts Constitution.[119] The Supreme Judicial Court of Massachusetts ultimately upheld the legislative actions. With respect to the article 10 challenge, the court noted that earlier construction of the relevant constitutional language established the proposition that " 'the Legislature has no power to suspend the operation of a general law in favor of an individual,' "[120] although it was evident that the court " 'has often upheld special legislation.' "[121] The court resolved this apparent conflict by interpreting article 10's proscription to apply only to situations in which benefits to the person singled out were

> accompanied by corresponding injury to another person who can be definitely pointed to . . . . [A]rt. 10 appears not to forbid a special or private act which, while assisting an individual, does not by its operation diminish or defeat an existing property interest of any other individual, or do other injury to him.[122]

The court upheld the special acts "because they [were] not shown to do injury to the interest of any individual or entity."[123] Perhaps recognizing the implications of its decision under the circumstances, the court chose not to give weight to the policies underlying the original departmental actions:

> There is a sense in which excessive or misguided construction and subsequent inefficient utilization of health care facilities may cast needless expense on the members of the public who foot the bill in the long run, and other adverse consequences to the public can be imagined, but these results, if they should eventuate, are not specific harms to identifiable persons with which art. 10 is concerned.[124]

The court left open the possibility that, if competitive applicants were disadvantaged by such special acts, then article 10's proscription could be activated. Apparently only under that circumstance could the added societal cost associated with unneeded construction rise to the level of a legally cognizable injury.

There is an irony here, some of whose significance is explored in a

118. 366 Mass. 734, 323 N.E.2d 309 (1975).
119. MASS. CONST. arts. 10, 30.
120. 366 Mass. at 742, 323 N.E.2d at 314.
121. *Id.*
122. *Id.* at 743, 323 N.E.2d at 314.
123. *Id.* at 744, 323 N.E.2d at 315.
124. *Id.* at 744-45, 323 N.E.2d at 315.

different context below.[125] Health insurance and governmental benefit programs were developed primarily to insulate citizens from the direct impact of hospital costs by spreading that financial burden across society through taxes and insurance. Yet, from the court's perspective, the availability of such risk spreading precludes otherwise appropriate parties from overturning special interest legislation that has the effect of increasing the overall cost burden to society. Arguably, if the citizens of the hospitals' service areas were still obliged to pay directly for their hospital care, instead of having the costs covered by insurance or governmental benefit programs, and it could be demonstrated that additional hospital investment increased the price of those services, then the requisite "harm to identifiable persons" would be established.

The court's analysis of the separation of powers issue under article 30 was substantially identical to its interpretation of article 10.

> The substantial question is whether the legislative enactment itself which dictates a given result involves an improper intrusion on the functions of another branch. This is a problem to be examined on the facts, and seems to us to turn at least in civil matters on whether that enactment infringes on proprietary rights or does other specific injury, so that the issue here is much like that under art. 10.[126]

In upholding the special acts, the court asserted its neutrality on the knotty qestion of the legitimacy of decisions rendered by DPH, but implied the propriety of using the legislature as a means of establishing "equity" in the administration of the DON program.

> It is not for us to indicate a judgment as to whether a course such as that taken by the Legislature . . . is merely a conspicuous invitation to log rolling *or, on the contrary, an understandable and even necessary means of introducing an occasional equity into a general statutory scheme* . . . . It is enough to say that legislative choices that were made in the present case cannot be assumed by us on the present record to have been against "the good and welfare."[127]

Following the 1977 session, the Massachusetts Legislature has continued to enact bills overriding DON decisions rendered by the DPH. As of September 1979, a number of such bills are awaiting gubernatorial action. While the DPH generally has opposed such override legislation, its main line of response has entailed the institution of procedural reforms of the DON process itself that served to deflect dissatisfaction with substantive decisions made by the DPH. Its theory

125. *See* text accompanying notes 178-199 *infra*.

126. 366 Mass. at 746, 323 N.E.2d at 316.

127. *Id.* at 750, 323 N.E.2d at 318 (emphasis added).

may be that political opposition to the program resulted not from opposition to the objectives of the program but from unhappiness about the length of time it took the DPH to process a project to conclusion and to reach a decision, and the uncertainty on the part of an applicant about the standards and criteria by which its proposed project could be evaluated. The inference is that it was believed that improved procedures and procedural rules could deflect political attacks on the program.

Acting on this presumed perception, both the DPH and the legislature initiated efforts to improve the DON process. Following enactment of the 1973 special bills, the DPH developed and promulgated amendments to the DON regulations "intended to improve the responsiveness of the process, to speed the processing of routine applications as well as making more explicit the criteria to be used by the Public Health Council in approving or denying applications."[128] In 1977, at the time the second group of special acts were under discussion, general amendments to the DON statute were adopted, requiring, for example, a shortened time period to process applications and mandating that applications be judged according to pre-established standards and criteria.[129] At the same time, efforts were undertaken to develop more explicit criteria to be employed in DON reviews.[130]

The 1977 amendments were, as indicated, predominantly in the nature of procedural reforms. With one exception they cannot be easily construed as attacks on the integrity of the objectives of the underlying regulatory program, although they did place a premium on an efficient processing of applications by the DPH.[131] The one exception related to the exemption from the DON program of certain research

128. *See* Bicknell & Van Wyck, *supra* note 24, at 11. *See also* Bicknell & Walsh, *Certification-of-Need: The Massachusetts Experience*, 292 NEW ENGLAND J. MED. 1054, 1059-1060 (1975).

129. Law of Jan. 9, 1978, ch. 945, 1977 Mass. Acts 1363 (codified at MASS. STAT. ANN. ch. 6A, § 35; *id.* ch. 111, §§ 25B, 25C, 25F, 25H (Law. Co-op Cum. Supp. 1978)).

130. *See* Mass. DON Regs., *supra* note 29, at pts. 60-65.

131. For example, the statutes now provide that DPH shall

> approve or disapprove in whole or in part . . . [an] application for a determination of need within eight months after filing with the department; provided that the department may, on one occasion only, delay such action for up to two months after the applicant has provided information which the department reasonably has requested during such eight month period. Applications remanded to the department [by the HFAB under MASS. ANN. LAWS ch. 111, § 25E (Law. Co-op 1975)] shall be acted upon . . . within the same time limits. . . . Any application which has not been acted upon by the department within such time limits shall be deemed to have been approved.

MASS. ANN. LAWS ch. 111, § 25C (Law. Co-op Cum. Supp. 1978). By contrast, the section originally provided that DPH "shall approve or disapprove, in whole or in part, *or otherwise act* upon every such application in a timely manner, but in any event within one hundred and twenty days after filing." Law of July 18, 1972, ch. 776, § 3, 1972 Mass. Acts 724 (emphasis added).

and teaching projects undertaken by hospitals.[132] There too, though, the legislature appears to have made an effort to retain the cost containment objectives of the basic program by excluding from the exemption research and teaching programs whose costs would have an impact on patient care charges.[133]

The efforts at procedural reform, as noted earlier, have not precluded further legislative overrides. The reform strategy may have failed, in part, because of the change of administration in Massachusetts in January 1979, and indications that the new governor would take a strong anti-regulatory stance.

Administration of the Chapter 409 program, unlike that of DON, has been relatively free of political controversy, at least as measured by legislative opposition.[134] It is instructive to speculate on why this is so. At least two factors may help account for the differences in reaction: the capacity of the RSC to employ a "formula" approach to implementing Chapter 409, and the gradualist or incrementalist philosophy embodied in the Chapter 409 statute. Each of these factors is described briefly below.

1. The Use of a Formula Approach To Ratesetting

The regulatory approach taken by the RSC involves two characteristics. First, it has been limited, at least to date, to relatively traditional cost analysis and does not attempt directly in the review process to incorporate less quantifiable considerations, such as quality or need. From this follows the second characteristic, which is the system's capacity to reduce operating principles used for developing allowable costs, revenues and charges, to definitional or mathematical formulae applied to historic and budgeted cost data.[135] The regulations governing the system define elements of cost, identify factors to be recognized in permitting changes in the hospitals' cost structure, and

132. *See* MASS. ANN. LAWS ch. 111, § 25C (Law. Co-op Cum. Supp. 1978).

133. *Id.* Among the conditions attached by the statute to permit an exemption from the required DON review for research and teaching purposes is the requirement that "the cost of such expenditure or change shall cause no increase in the total patient care charges of the [applicant] facility to the public . . . , as such charges shall be defined from time to time . . . [by the RSC under Law of Oct. 15, 1976, ch. 409, § 5, 1976 Mass. Acts 529]." On the subject of this exemption, see Friedman, *Federal Preclusion of State Certificate-of-Need Exemptions for Research and Education Expenditures*, 4 AM. J. L. & MED. 91 (1978).

134. Organized opposition to Chapter 409 has taken the form of direct judicial challenge, not legislative amendment. *See* Affiliated Hosps. Cent., Inc. v. Weiner, No. 22824 (Suffolk Sup. Ct. 1978); Affiliated Hosp. Cent., Inc. v. Weiner, No. 19457 (Suffolk Sup. Ct. 1977).

135. For examples of the types of formulae employed, see Massachusetts Rate Setting Commission Regulation 114.1 C.M.R. § 8.00 (1978).

establish formulae for quantifying those factors in analyzing an individual hospital's experience.

An important feature of the formula approach is that it does not vest much discretion in individual staff members of the agency, or even in the Commissioners themselves, to vary the rules or make personal equitable judgments in individual cases. This is in contrast, for example, with budget negotiation systems in which there is an absence of explicitly established rules and many discretionary decisions are made during the review of a particular budget.[136] On the other hand, a formula approach may be unduly rigid and insensitive to genuine equitable needs arising in unique or unusual circumstances. The formula approach does, however, have a significant advantage in removing policy formulation from individualized and highly discretionary personal judgments and placing it at the point at which regulations incorporating the formulae are developed and promulgated. A number of benefits accrue to the RSC from this reliance on a rulemaking approach:

First, judicial review is ordinarily sought as an attack on the regulation, not on the specific application of the regulation. In defending itself, the RSC enjoys the presumption in favor of its action in implementing its statutory authority.[137] This posture contrasts with that of other ratesetting programs that rely on negotiations with hospitals and informal guidelines developed for application during the negotiation process.[138]

Second, rules of general applicability are developed with sufficient specificity to minimize agency discretion and are then applied consistently to all providers. The result is that hospitals generally feel that they have been treated fairly, that is, consistently, in the process. This "perception of fairness" may be a prerequisite for avoiding substantive as well procedural attacks on a regulatory program.

Finally, reliance on rulemaking moves complaints about the process away from individual decisions to the more distant, technical, and abstract rulemaking process itself. Use of rulemaking and the develop-

136. For a description and discussion of these approaches, see Danbury Hosp. v. Commission on Hosps. and Health Care, No. 18958 (Ct. of Common Pleas, Fairfield County, Conn. 1978); New Britain Gen. Hosp. v. Commission on Hosps. and Health Care, No. 13 24 86-1 (Ct. of Common Pleas, Hartford County, Conn. 1977); Franklin Square Hosp. v. Health Serv. Cost Review Comm'n, No. 82047 (Baltimore County Ct., Md. 1975).

137. *See* Affiliated Hosps. Cent., Inc. v. Weiner, No. 22824, at 24-25 (Suffolk Sup. Ct. 1978).

138. *See* Danbury Hosp. v. Commission on Hosps. and Health Care, No. 18958 (Ct. of Common Pleas, Fairfield County, Conn. 1978); New Britain Gen. Hosp. v. Commission on Hosps. and Health Care, No. 13 24 86-1 (Ct. of Common Pleas, Hartford County, Conn. 1977); Franklin Square Hosp. v. Health Serv. Cost Review Comm'n, No. 82047 (Baltimore County Ct., Md. 1975).

ment of technically complex formulae make it difficult to identify an effective time at which to mobilize opposition to the program. To the extent that the rules are technical, most potential opponents would find it difficult to build support on the basis of dimly perceived policy implications that are being attacked. To the extent explicit rules are applied consistently, opponents cannot rely on inequitable administration as a political lever for change or as a legal argument.

In contrast to the Chapter 409 program, the DON program has not enjoyed reliance on technical formulae and rulemaking. The enabling act contains language that could permit reduction of rules governing decisionmaking to mathematical constructs,[139] but until relatively recently such an effort has not been made on a significant scale.[140] In ordinary language, "need" is a highly subjective concept that must be analyzed by examining a multiplicity of factors. The RSC limits itself to cost analysis, whereas the DPH cannot so restrict its scope of inquiry but must of necessity venture into a variety of subjective or discretionary areas of evaluation.[141] Some but not all of the relevant factors can be reduced to mathematical precision for purposes of evaluation. Even relatively precise guidelines, however, will often leave much discretion with the agency concerning their application in specific circumstances. In such situations, if the agency does not articulate clearly the reasons for a particular decision, or fails to develop a set of "common law" principles enabling it to identify consistent lines among different outcomes,[142] an individual decision may be challenged as unfair, inequitable or inconsistent with treatment provided to similar applicants. Further, in the absence of reliance on rulemaking, policies or interpretations may change from one application to another, but the agency may have no formal capacity to notify applicants of the changes. This

139. *See* MASS. ANN. LAWS ch. 111, § 25C (Law. Co-op 1975).

140. *See* text accompanying notes 43 & 129 *supra*.

141. *See, e.g.*, Bachman, *Health Planning—The Next Step*, 3 HEALTH L. PROJECT BULL. 1 (1978); Bicknell & Walsh, *supra* note 128, at 1059; Bovbjerg, *Problems and Prospects for Health Planning: The Importance of Incentives, Standards, and Procedures in Certificate of Need*, 1978 UTAH L. REV. 83, 90-97. *See also* Schonbrun, *Making Certificate of Need Work*, this Symposium, at text accompanying notes 27 & 28, 93-101.

142. The DPH staff has, on a number of occasions, considered undertaking a detailed analysis of Public Health Council minutes and records to determine the operative rules and factors that actually structured the decisions on DON applications and developing, in effect, a common law approach toward applicable rules. Conversations with David Rosenberg, DPH General Counsel, 1973, and with Jacob Getson, Director, Office of State Health Planning, DPH, 1979. Such an approach would constitute an alternative or supplement to the standards and criteria development process described in the text accompanying notes 83 & 84 *supra*.

may enhance the feeling of unfairness on the part of the subject hospitals.

The subjectivity of the definition of "need" complicates the political life of a DON agency in another respect. DON applications are ordinarily the product of an internal decisionmaking process in which the hospital itself proceeds to identify and respond to community need. When an application is filed, the regulatory agency must reassess that need determination process and place it in the context of its statewide policies and objectives, rather than merely those of the institution or even the local community. Consequently, very different perceptions of "need" may be at play, and an adverse regulatory decision may not be accepted when the local community feels that the individual hospital actually does have an accurate perception of its "need."

2. Gradualism

Both DON and ratesetting are relatively new regulatory programs. The sophistication of the analytic techniques available to support their decisions is still in an early state of development.[143] When a regulatory program must rely on an evolving technical state of the art, a number of strategic options are available: regulatory authority may be withheld until the analytic support for reasoned and consistent decisions is available; general regulatory authority may be established, but certain classes of decisions may be precluded pending further analytic developments; or the inadequacy of the underlying techniques may be ignored, so that an agency may be required to render regulatory decisions even absent adequate or generally accepted technical grounds.[144]

DON in Massachusetts, at least until the 1977 amendments,[145] followed the third option. Although the DPH was given extensive DON authority in the 1971 and 1972 enactments, at the time very little in the way of standards and criteria for evaluating need had been developed,

143. HEW is, for example, currently funding major evaluation studies of certificate of need and ratesetting programs in a number of states. The certificate of need study is being undertaken by Urban Systems Planning and Engineering, Inc., Cambridge, Mass., and that of ratesetting programs by Abt Associates, Inc., Cambridge, Mass.

144. *See* Weiner, *State Regulation and Health Care Technology*, in TECHNOLOGY AND THE QUALITY OF HEALTH CARE 218-221 (Egdahl & Gertman eds. 1978). An excellent example of the difficulties posed for reviewing courts where agencies make decisions under the circumstances described in the text appears in the various opinions and statements regarding the appropriate scope and standards for judicial review by members of the United States Court of Appeals for the District of Columbia Circuit in Ethyl Corp. v. EPA, 541 F.2d 1 (D.C. Cir. 1976), *cert. denied*, 426 U.S. 941 (1976).

145. *See* text accompanying notes 131 & 132 *supra*.

and very little analytical work had been undertaken to develop standards and criteria that could generally be accepted as valid for implementation in a DON program. Indeed, the major incentive for developing such standards and criteria did not occur until 1975, with enactment of the National Health Planning and Resources Development Act.[146] Thus, much of the history of the DON program after 1971, and especially after 1975, entailed efforts to develop specific analytic techniques and an effective health planning process to provide a basis of support for DON decisions. Absent these efforts, little ground existed for explaining individual decisions in a broader context, for identifying consistencies in decisions, or for acceptance of the DPH's "expertise" in administering the program.

In contrast, the drafters of Chapter 409 recognized the evolutionary nature of ratesetting and structured the statute in line with that recognition. The approach taken was not a blanket authorization to the RSC to undertake charge or budget control. Such an approach might have generated unrealistic expectations concerning the RSC's capacity to administer a fully effective program. Had such an expectation forced the RSC to initiate a more ambitious program than that of which it was technically capable, the program would likely have proved a disaster.

Instead of a sudden and sweeping mandate, Chapter 409 reflected a philosophy of starting with what was known and building gradually. Techniques for the control of rates of increase, such as inflation projections and volume adjustment formulae, were familiar to most Massachusetts hospitals through their participating agreement with Blue Cross,[147] and through some of the conceptual developments in the later stages of the federal economic stabilization program.[148] The hospitals were also used to working with Medicare's definition of cost.[149] Thus, Chapter 409 relied in its first years of implementation on a definition of "total patient care costs" tied to Medicare's definition of allowable cost categories,[150] and on analytic techniques already familiar in the

146. National Health Planning and Resources Development Act of 1974, Pub. L. No. 93-641, 88 Stat. 2225 (1975) (codified at 42 U.S.C. §§ 300k, 300t (1976)).

147. *See* Blue Cross of Massachusetts, Inc., Participating Hospital Agreement HA-25-TH, art. IV, § 4, at 18-22 (1973).

148. *See* 6 C.F.R. §§ 150.705-.706 (1974).

149. Medicare's definitions of cost allowable for reimbursement under the program are set forth at 42 C.F.R. §§ 405.401-.488 (1977).

150. Law of Oct. 15, 1976, ch. 409, § 5, 1976 Mass. Acts 522. *See also* Affiliated Hosps. Cent., Inc. v. Weiner, No. 22824, at 22-31 (Suffolk Sup. Ct. 1978).

state.[151] The statute identified specific gaps in the system, such as the eventual inadequacy of the Medicare definition in the context of a budget control program[152] and the need to incorporate analyses of current or base year cost levels through techniques of comparing the costs of like institutions.[153]

Finally, Chapter 409 required the RSC to address these gaps over a period sufficiently long to permit the development of viable analytical approaches, which were then to be incorporated into the control system. Chapter 409 became effective on October 15, 1976. The RSC was directed to revise the definition of "total patient care cost" by October 1, 1978,[154] and to develop a methodology for grouping hospitals for comparative purposes by October 1, 1979.[155] Behind this approach was the desire to enhance the agency's competence to handle more sophisticated techniques before they were actually employed in a regulatory decisionmaking process.

Other examples of this gradualist approach appeared in specific administrative decisions made by the agency during the early phases of implementation. These included the decision to continue use of traditional hospital charge schedules instead of requiring a standard payment unit.[156] A similar philosophy underlay the RSC's sensitivity to the appropriate allocation of decisionmaking responsibilities between itself as a public agency and the hospital as a private institution. Thus, for example, principal emphasis in the Chapter 409 program is on development of a "bottom line" amount representing maximum allowable revenue available to the hospital annually.[157] Expenditure of this allowable revenue is not rigidly allocated to individual departments or line items. In effect, the hospital management was expected to make its

151. For example, MASS. STAT. ANN. ch. 6A, § 37 (Law. Co-op Cum. Supp. 1978) allows the RSC to approve a modification in charge proposed by a hospital if "the increase proposed is consistent with the rate of inflation in the economy generally, as measured by a composite price index to be specified in such regulations [of the RSC] and based, to the extent practicable, on any index approved by the commission and contained in [Blue Cross agreements approved by the RSC under *id.* ch. 176A, § 5 (Law. Co-op 1977)]."

152. *See* Law of Oct. 15, 1976, ch. 409, § 5, 1976 Mass. Laws 522.

153. *See* MASS. STAT. ANN. ch. 6A, § 40 (Law. Co-op Cum. Supp. 1978).

154. Law of Oct. 15, 1976, ch. 409, § 5, 1976 Mass. Laws 522.

155. MASS. STAT. ANN. ch. 6A, § 40 (Law Co-op Cum. Supp. 1978).

156. *See* Massachusetts Rate Setting Commission Regulation, 14 C.H.S.R. § 4 (1975).

157. Massachusetts law provides that the RSC "shall approve or disapprove in whole or in part *only* the total patient care costs and total patient care charges projected by the applicant or filing hospital." MASS. ANN. LAWS ch. 6A, § 40 (Law. Co-op Cum. Supp. 1978) (emphasis added). The implication is that approval goes to the total figures and not to any departmental breakdown that may be used in constructing the aggregate figures. "Total patient care costs" and "total patient care charges" are defined in Law of Oct. 15, 1976, ch. 409, § 5, 1976 Mass. Acts 522.

own decisions concerning the use of available financial resources, so long as the "bottom line" was not exceeded.

This gradualist approach also meant, of course, that the system would become increasingly rigorous over time, with its full potential impact being deferred for some years. It may be likely, therefore, that political opposition to the program has been deferred, with hospitals adopting a wait and see attitude while the additional elements of the program are developing. And, indeed, some of the RSC's approaches to satisfying the statutory mandate have already generated significant concern and opposition from hospitals.[158] With the full operation of the program scheduled for October 1, 1979, (with the addition of the technique for comparing hospitals) bills have now been introduced into the 1979 session of the legislature, supported by the Hospital Association or other hospital representatives, to modify or defer portions of the Chapter 409 enabling act.[159] The current session of the legislature may provide some evidence on the question whether, despite the different approaches to decisionmaking taken by DON and Chapter 409, they may nonetheless both be equally subject to significant and effective political opposition.

158. For example, in March 1978, the RSC circulated publicly an issues paper concerning the definition of "reasonable financial requirements" that it was to adopt by October 1, 1978, pursuant to Law of Oct. 15, 1976, ch. 409, § 5, 1976 Mass. Acts 529. *See* Financial Requirements Under Chapter 409—Background and Issues. The paper was presented at a series of public hearings held for hospital trustees, administrators and financial staffs in March and April of 1978. Among other matters, the paper dealt with possible uses of hospital restricted and unrestricted income and charitable contributions in the budget review and approval process. The hospital response to suggestions in the paper that nonpatient sources of revenue might be used in defining "reasonable financial requirements" was strongly negative. *See, e.g.*, MASSACHUSETTS HOSPITAL ASSOCIATION, THE ROLE OF RATE SETTING, FINANCIAL REQUIREMENTS, AND STATE HEALTH POLICY IN YOUR HOSPITAL (1978); NEW ENGLAND ASSOCIATION FOR HOSPITAL DEVELOPMENT, THE ROLE OF PHILANTHROPY IN MASSACHUSETTS HOSPITALS: A SPECIAL REPORT TO THE RATE SETTING COMMISSION, COMMONWEALTH OF MASSACHUSETTS (1979).

H. No. 3466, which was introduced into the 1979 session of the Massachusetts legislature, proposes to preclude use by the RSC of unrestricted and restricted income in calculating charges or approving budgets. The Joint Legislative Committee on Health Care has voted approval of the bill.

159. H. No. 3466 (1979) proposes to preclude use by the RSC of unrestricted and restricted income in calculating charges or approving budgets. *See* note 158 *supra*. H. No. 3478 (1979) would defer imposition by the RSC of uniform reporting requirements pending federal development of uniform reporting regulations. H. No. 3479 (1979) would delay the requirement of Chapter 409 that the RSC develop a methodology for grouping hospitals until uniform reporting requirements are established. The Joint Legislative Committee on Health Care, in April 1979, voted to support H. No. 3466 and to reject H. No. 3478 and H. No. 3479.

IV. Factors Suggesting Lack of Political Support for Cost Containment

A. Introduction

The analyses undertaken in the preceding section suggest some tentative conclusions. First, there may be only limited circumstances in which the capacity for general public participation in the cost containment regulatory process may be effective. Such circumstances involve a combination of two elements: a structured opportunity for diverse interest groups to participate and possession by the group of a relatively high level of technical expertise. Thus, the analysis suggests that the RSC Advisory Council has not been successful, either in changing RSC positions or in providing support for its program objectives, whereas the Hospital Policy Review Board has been an effective participant.

Second, the availability of extensive opportunities for public participation in agency proceedings is not correlated with effective political support for agency programs. Despite substantial opportunities for general public and interest group involvement in the review of DON applications, the program was not able to withstand political attacks culminating in legislative overrides of specific decisions.[160] While the RSC has not yet been subject to equivalent political difficulties, it is not yet certain whether similar openness in the Chapter 409 process will provide useful support to the RSC in the face of intensified hospital opposition. Further, the possibility for participation in such proceedings, except perhaps when they are highly structured, as in the case of the Hospital Policy Review Board, has not provided a mechanism for the regulatory agencies to undertake public education to develop support.

Third, other procedural issues may be more significant in determining the effectiveness of political opposition to the regulatory program than the question of who may participate in the agency's decisionmaking process. Processing time, clarity of the "rules of the game," consistency in decisionmaking and confidence in the competence of the decisionmaker may all be more conducive to providing political support for the program, or at least neutralizing political opposition, than public participation in agency processes.

An evaluation of the relationship between public participation and

160. *See* text accompanying notes 114-127 *supra*.

political support, however, must consider the nature of the constituency groups likely to be interested in participating in a hospital cost containment agency's processes, and the political position of such groups with respect to the agency's objectives. An implicit assumption of the foregoing analysis has been that there were sufficient nonprovider interest groups supportive of the agency's reformist objectives to permit the conclusion that the agency's objectives reflected the "public interest." But if, as it appears, the role of public participation has had relatively little impact on the political status of the particular program, perhaps the phenomenon is due to the very nature of the constituencies themselves. In short, is there any constituency group likely to provide continuing and strong support to the cost containment objectives of the DPH in administering DON or the RSC in administering Chapter 409? One could infer from the preceding analysis that a group's support for a cost containment program is a function of its immediate and particular interests, not necessarily reflecting general support of program objectives, and that cost containment is not generally viewed by the public at large as a significant policy objective. Therefore, the willingness of any particular interest group to support general program objectives will last only so long as and to the extent that those objectives directly benefit the relevant interest group. While such a conclusion is hardly surprising, it does nonetheless suggest the tenuous nature of political support for cost containment objectives and the need for the regulatory agencies to develop clear evidence and statements concerning the relationship between their goals and the particular interests of affected groups.

Estimating potential public support for cost containment becomes increasingly important as the Massachusetts regulatory agencies attempt, on the basis of ambiguous statutory authority, to move beyond the explicit statutory authorizations of DON and Chapter 409 to encourage or require mergers or closures of services and institutions.

B. Potential Constituencies for Cost Containment

A persistent question is why should a regulatory agency attempting to achieve cost containment objectives in the hospital field have difficulty developing broad public support among nonhospital interests? A number of organized constituency groups emerge as logical supporters of cost containment objectives: government itself, particu-

larly as a major purchaser of hospital services through Medicare[161] and Medicaid[162]; insurers, who must translate hospital costs into insurance premiums; business and labor, as groups primarily responsible for purchasing insurance to provide financial protection against the risks of hospitalization; and the elderly, who pay a certain portion of medical expenses out of pocket despite Medicare. While each of these groups represents potential supporters of cost containment, the capacity of each to provide effective and consistent political support to the cost containment objectives of regulatory agencies is affected by certain basic structural characteristics of the hospital delivery system — specifically the role of government, the role of insurance and the status of hopsitals themselves. Each of these characteristics, and its impact on potential constituencies for cost containment, is explored in the following sections.

1. The Role of Government

The federal and state governments perform multiple functions in the hospital delivery system. Of greatest significance for purposes of this analysis are their responsibilities for purchasing and regulating services.[163] Through Medicare and Medicaid, the financing of hospital services on behalf of defined populations is shared by both levels of government. The federal government has the greater fiscal obligation because of the structure of Medicare[164] and its cost sharing responsibilities under Medicaid.[165] State governments are more immediately and continuously faced with the costs of supporting Medicaid because they must annually appropriate the full amount necessary to operate the program, subject to reimbursement of a specified percentage from the federal government.[166] Aside from financial responsibility, state government has traditionally been the primary unit for regulating hospital services, a role reinforced by the National Health Planning and Re-

161. 42 U.S.C. § 1395F(b) (1976).

162. *Id.* § 1346 (1976).

163. Weiner, *supra* note 144, at 211-215.

164. The primary sources of payment for Medicare benefits are the Federal Hospital Trust Fund, established by § 1817 of the Social Security Act, 42 U.S.C. § 1395i (1976), and the Federal Supplementary Medical Insurance Trust Fund, established by § 1841 of the Social Security Act, 42 U.S.C. § 1395t (1976). Sources of revenue for the trust funds are payroll taxes and beneficiary premiums.

165. *Id.* § 1396b sets forth the provisions concerning the financial responsibility of the federal government for Medicaid.

166. *See, e.g.*, 44 Fed. Reg. 10,553 (1979) (setting forth the federal medical assistance percentage per state for the period October 1, 1979 through September 30, 1981).

sources Development Act.[167]

At least in states with large Medicaid programs, such as New York and Massachusetts, the state's responsibility for financing hospital services has been a major determinant of the position of its executive on regulating the costs of those services. Both New York and Massachusetts originally undertook cost containment programs directly tied to their Medicaid responsibilities, and thus attempted regulation through the medium of financing.[168]

But this approach may produce at least two potentially inequitable effects. The first effect may be an increased differential between Medicaid rates and rates paid by other purchasers for the same hospital services, with Medicaid paying less. This effect occurs because of the way in which the payment rates for hospital services are developed. In simplest terms, hospitals are paid on the basis of "cost" or "charges." Blue Cross, Medicare and Medicaid generally develop their payment rates on the basis of the cost figures of the particular hospital.[169] Yet the rates for all cost-based payors for the same services are not the same because of the different definitions of allowable cost that may be used in drawing up rates.[170] Thus, the Medicaid program may employ a restrictive definition to achieve cost containment objectives, whereas Blue Cross and Medicare may use a less restrictive approach. In such a circumstance, costs that are not recognized for Medicaid purposes are included in developing Blue Cross and Medicare rates. The latter rates will therefore be higher than Medicaid's. Further, the hospital's decision to incur costs that will not be reimbursed by Medicaid, but will be paid by Blue Cross and Medicare, will be a function of the number of patients covered by, and the proportion of hospital patient care revenue received from, the respective programs. If Medicaid accounts for only ten percent of hospital revenue, whereas Blue Cross and Medicare combined account for seventy-five percent, the hospital is likely not to structure its cost decisions based on Medicaid's principles, but rather to

167. 42 U.S.C. §§ 300k-300t (1976). The Act requires that states must adopt a certificate of need program satisfactory to the Secretary of HEW. *Id.* § 300m-2(a)(4)(B) (1976). The constitutionality of this provision was upheld in North Carolina *ex rel.* Morrow v. Califano, 445 F. Supp. 532 (E.D.N.C. 1977), *aff'd mem.*, 98 S. Ct. 1597 (1978).

168. Weiner, *supra* note 25, at 15-21, 24-27, 27-28 n.74.

169. *See* MASS. ANN. LAWS ch. 176, § 5 (Law. Co-op 1977) (Blue Cross of Massachusetts); 42 U.S.C. § 1395f(b) (1976) (Medicare); *Id.* § 1396a(13)(d) (1976) (Medicaid).

170. For example, Massachusetts Medicaid and federal Medicare rates provide for straight-line, historical cost depreciation, but until recently Massachusetts Medicaid used 50 years as the standard building life, while Medicare uses 40. Massachusetts Blue Cross, on the other hand, uses price level depreciation. Chapter 409 allows recognition for bad debt and free care, while Massachusetts Medicaid does not. Law of Oct. 15, 1976, ch. 409, § 5, 1976 Mass. Acts 522.

accept a loss of only approximately ten percent of that portion of its cost not reimbursed by Medicaid.

A hospital's capacity to absorb this "Medicaid loss" is enhanced by its freedom to raise charges. Certain classes of purchasers, specifically commercial (non-Blue Cross) and self-pay patients, pay charges that hospitals in most states are free to establish on any basis whatsoever, whether or not cost-related.[171] Under such circumstances hospitals are able to increase charges to offset in part the amount of the "Medicaid loss."

Thus, because of either the differences in definitions of allowable cost used by cost-based purchasers, or the capacity of hospitals to increase charges free of regulatory controls, efforts to use Medicaid to contain costs would produce differentials when Medicaid was paying less than other purchasers for identical hospital services.

While such a result may be acceptable from the state's perspective as a purchaser, it is troubling in the context of the state's general police power responsibilities to protect the public health and welfare. By regulating only Medicaid rates, and not overall costs or charges directly, the state is in effect increasing the price of hospital services to non-Medicaid patients for the benefit of its own program.

The second effect may be that hospital costs are not constrained at all. For example, under the terms of the Medicaid prospective formula employed in Massachusetts,[172] when a particular year becomes the base year for the rate calculation, the full Medicaid allowable costs for that base period are recognized.[173] As a result, the prospective formula does not reduce the rate of increase in hospital costs, but merely defers the impact of past increases on Medicaid rates.[174]

171. *See* Massachusetts Rate Setting Commission Regulation, 114.1 C.M.R. § 3.00 (1978).

172. *Id.* § 3.05(5), 3.07. Under the original prospective methodology adopted by the Massachusetts Rate Setting Commission to determine Medicaid rates for in-patient hospital services, the "base year" was the second year prior to the rate year. That is, for fiscal year 1975 rates, the base year was fiscal year 1973. *See* Massachusetts Rate Setting Commission Regulations 74-1 (1974), 74-26 (1974), 14 C.M.S.R. 3 (1975). Medicare allowable costs in the base year, with certain specified exceptions, were adjusted to develop rate year allowable costs. Effective January 1, 1978, that methodology was changed; although the second prior year continued to be defined as the base year, allowable base year costs were adjusted by using the third prior year's costs and projecting them forward to the base year before adjusting base year cost to develop rate year cost. The Medicare allowable costs in the third year prior to the rate year provide a basis for developing rate year rates. *See generally* Massachusetts Rate Setting Commission Regulation, 114.1 C.M.R. § 3.00 (1978).

173. *See* Testimony of Stephen M. Weiner, Chairman, Massachusetts Rate Setting Commission, before Joint Legislative Committee on Health Care, on H. 3160 (March 1976). *See also* Weiner, *supra* note 25, at 44 n.117.

174. *See* Message from Governor Michael S. Dukakis to The Honorable Senate and House of

Because of continuing increases in Medicaid expenditures, even with its prospective formula, the state administration in Massachusetts had the choice in 1975 of further modifying the rate formula, which would have had the effect of further increasing the differential between Medicaid and other rates, or shifting the basis for cost containment strategies from reliance on purchasing responsibilities to reliance on the general police power authority. This was the political origin of Chapter 409. The primary political support for the program came from the administration and from the legislative Ways and Means Committees, the members of which were concerned about Medicaid expenditures. They saw regulation of charges and control of hospital budgets as the means for effectively limiting Medicaid costs.[175] Although the general societal and economic benefits of such a program were also emphasized,[176] it seems unlikely that the program would have been enacted in the first place without the impetus of the Medicaid budget.

A similar development has been occurring at the federal level. Originally, federal cost containment efforts were tied to purchasing responsibilities.[177] But increases in federal obligations for Medicare and Medicaid moved the Carter Administration to endorse general revenue controls, not merely controls over revenues derived from federal sources.[178]

It may be expected that the executive department's concern about its continuing responsibility for financing hospital care will make it particularly sensitive to the need for controlling the costs of that care and that it will continue active efforts to foster cost containment objectives. Such efforts will proceed from the dual motivation of police power concerns about the general public good and narrower budgetary concerns about the cost of government health care programs. Never-

Representatives, April 15, 1975, contained in H. No. 6092 (1975). Appendix C of the Governor's Message consisted of a proposal to freeze hospital charges until June 30, 1976, and initiated the legislative process producing Law of July 9, 1975, ch. 424, 1975 Mass. Acts 449. H. No. 6092 contained a series of bills intended to "bring the budget of the Department of Public Welfare under control." That Department is the responsible agency for administering the state Medicaid program. *See* MASS. ANN. LAWS ch. 118E (Law. Co-op 1975 & Cum. Supp. 1978). *See also* Stephen M. Weiner, Chairman, Massachusetts Rate Setting Commission, Testimony in Support of H. 6092, Appendix C, On Behalf of His Excellency, Governor Michael S. Dukakis, the Executive Office of Human Services, and the Massachusetts Rate Setting Commission, May 27, 1975, at 3-4 [hereinafter cited as Testimony in Support of H. 6092].

175. *See* Testimony in Support of H. 6092, *supra* note 174, at 3-4.

176. Weiner, *supra* note 25, at 28-36.

177. H.R. 6575, 95th Cong., 1st Sess. (1977); S. 1391, 95th Cong., 1st Sess. (1977).

178. For a discussion of the impact of Medicare and Medicaid on the market for health care services, see Posner, *Regulatory Aspects of National Health Insurance Plans*, 39 U. CHI. L. REV. 1, 2 (1971).

theless, because of the substantial purchasing responsibilities of government, it it likely that the cost containment initiatives will be viewed by affected interest groups as arising predominantly from budgetary concerns. As a purchaser, the executive department of government may be considered as no different from any other interest group acting in and around the hospital delivery system. Its pronouncements and attitudes will not be accorded any greater weight than those of other interests. If its position is not viewed as generally conducive to the public good, then, like any other interest group, it will still have to persuade other interests to support its objectives.

Under such circumstances, that a cost containment regulatory agency may be pursuing its objectives with the support of other executive agencies, including the chief executive, does not assure it of strong political support. Its political efficacy will be a function of the relative bargaining power between the executive and legislative branches, the role of the ways and means committees within the legislature (assuming they understand and support the link between cost containment and budget), and the identification by other interest groups with the executive's objectives. Political support for such an agency will still then depend in large measure on the willingness of other groups to support it. The availability of that support, specifically from nonprovider interest groups, is related to the second characteristic of the hospital delivery system—the role of insurance.

2. The Role of Insurance

Insurance is often credited with eliminating traditional market mechanisms in the hospital delivery system. To the extent that insurance insulates direct consumers of hospital services from the actual cost of those services, especially inpatient services, it removes price as a consideration in any consumer choice with respect to the quantity and location of hospital services. Probably more significantly, since demand for acute inpatient hospital services is usually generated by physicians rather than by the ultimate consumer, the availability of insurance has removed price as a factor in decisions by physicians about the type, quantity or location of such services to be provided patients. The direct price of a service, then, does not ordinarily function to allocate hospital resources in the way traditional supply and demand models presume.

Although the price of the particular service may no longer serve as a primary device of resource allocation, the price of insurance itself appears to be assuming that function. As the preceding section de-

scribed, the price of government "insurance," through Medicare and Medicaid, has generated cost containment efforts by the parties responsible for paying that price, the federal and state governments. Parallel efforts are beginning to occur in the private sector as well, in which the price of insurance is reflected not only in tax levies to support the governmental programs but in expenditures to pay the premiums necessary to provide for private (Blue Cross and commercial) insurance coverage. Increases in the cost of insurance generally reflect increases in the direct cost or price of the services purchased through insurance. In effect, the price of insurance is becoming a surrogate for the price of services in mobilizing "consumers" to exercise economic leverage to produce more favorable prices. In this case, however, the "consumer" is not the ultimate user of the hospital service, or even the physician prescribing the service, but the party who is financially responsible for paying for the insurance policy.

The principal interest groups affected by increases in insurance prices are employers, employees and the elderly.[179] A substantial proportion of Blue Cross and commercial health insurance is marketed through employer groups. In many cases, the employer will assume some portion of the premium involved in purchasing the insurance. The expense so incurred is allowable as a tax deduction under the Internal Revenue Code,[180] and is not treated as income to the employee.[181] The balance of the premium expense is borne by employees, who may take some portion of the expense as a tax deduction.[182] Increases in hospital costs will push up the cost of insurance to employers and employees, thereby making these groups potential supporters of cost containment programs.[183]

The impact of the increasing cost of hospital care is also felt in the out-of-pocket expenditures of the elderly. Indeed, despite the advent of Medicare, actual out-of-pocket expenses incurred by the elderly for re-

179. The role of these nonprovider interests is specifically recognized in the composition of the Hospital Policy Review Board. *See* text accompanying notes 56 & 57 *supra*.

180. *See* I.R.C. § 162.

181. I.R.C. § 106. *See generally* Havighurst, *More on Regulation: A Reply to Stephen Weiner*, 4 AM. J. L. & MED. 243, 248 (1978).

182. I.R.C. § 213.

183. Both groups have been identified as potential sources of support for the efforts at obtaining charge and budget control legislation. Indeed, much of the effort undertaken by the Dukakis Administration in Massachusetts in its strategy that led to enactment of Act of Oct. 15, 1976, ch. 409, 1976 Mass. Laws 522, involved attempts to obtain public commitments from representatives of these two groups. (Material in personal files of the author.) A similar strategy has been undertaken by the Carter Administration nationally in an effort to secure enactment of its proposed Hospital Cost Containment Act.

ceiving medical services have increased since the mid-1960s.[184] Among the sources of this increase are increases in the amount of co-insurance for Medicare[185] and in the price of supplemental insurance purchased to cover Medicare co-insurance and services not provided under Medicare.

The economic effect of increases in the cost of coverage has placed pressures on the insurers themselves to implement strategies to contain that cost. Only two strategies appear available to them: reducing the level of benefits provided under any particular policy's coverage, either by eliminating coverage for certain services or by instituting or expanding co-insurance features, or seeking to contain increases in the underlying cost of the services purchased. The former strategy is a limited one: although there appear to have been occurrences of decreased coverage, there is continuing pressure, particularly from the larger unions, to increase the scope of benefits provided under group insurance arrangements and to oppose any increased use of co-insurance. Further, any decreases in the types of services covered would likely not be in the highest cost area of acute inpatient hospital services. Another factor militating against use of this strategy is the appearance of state statutes mandating certain kinds of coverage.[186] Thus, effective impact on the rate of increase and the price of premiums could be achieved, if at all, only by the second strategy; it is significant to note in this context that both Blue Cross and commercial insurance carriers in Massachusetts have been supportive of state cost containment efforts.[187]

The price of insurance, then, creates incentives for affected constituencies to support hospital cost containment. Yet there are countervailing factors that reduce the consistency and fervor of such support. Three factors particularly affect the capacity of the business community to provide active leadership for cost containment. First, business' traditional distrust of government regulation produces the attitude that "if we support regulation of them, might it not increase regulation of us?" While it is possible to differentiate the need for regulation in the health

184. Mueller & Gibson, *Age Differences in Health Care Spending, Fiscal Year 1975*, 1976 SOC. SEC. BULL. 18, 19.

185. Section 1813 of the Social Security Act imposes a requirement on Medicare program beneficiaries for payment of certain deductibles and co-insurance portions. 42 U.S.C. § 1395e (1976).

186. *See, e.g.*, MASS. STAT. ANN. ch. 175, § 47B (Law. Co-op 1977) (mandating coverage for certain mental health services).

187. Personal communications to the author by representatives of these groups.

field from the need for regulation in other areas of the economy,[188] the distinction may be irrelevant in the context of general interest in deregulation and widespread distrust of government. Thus, business is very likely to support nongovernmental efforts to contain costs, but tends to be at best ambivalent about the role government should play in regulating hospitals.[189]

Second, executives of business organizations often serve on the boards of local hospitals.[190] Consequently, there may be a perceived conflict between corporate support of cost containment strategies aimed at hospitals and the fiduciary responsibilities of corporate executives as hospital trustees. Even if no legal conflict may exist, a corporate spokesperson's service on a hospital board may inhibit him or her from giving strong public endorsement of regulatory initiatives intended to restrict the cost behavior of hospitals generally.

Finally, it is not clear that the success of cost containment strategies will be of a direct benefit to employers. Premium payments are, after all, tax deductible. Further, to the extent some savings are achieved in premium expense, it is likely that employee benefit policies or collective bargaining will produce a reallocation of such "savings" into other areas of employee benefit expense. So, unless the employer has a strong preference concerning the type of fringe benefits it wishes to provide, savings from premiums may be a matter of indifference.

Similarly, organized labor has reason to be ambivalent about the potential success of cost containment programs. Major unions are likely to suffer direct adverse effects. Construction workers stand to lose job opportunities because of construction deferred or abandoned as a result of certificate of need decisions. And nonsupervisory workers fear that they will be the first affected by application of external budgetary constraints on hospitals. Consequently, general union support for cost containment efforts may be conditioned on exceptions for costs as-

188. *See* Havighurst, *Health Care Cost Containment Regulation: Prospects and an Alternative*, 3 AM. J. L. & MED. 310, 311-312 (1977).

189. *See, e.g.*, NATIONAL CHAMBER FOUNDATION, A NATIONAL HEALTH CARE STRATEGY: HOW BUSINESS CAN IMPROVE HEALTH PLANNING AND REGULATION (1978). The Executive Summary of this report stresses the importance of businesses participating in public health planning agencies and private health planning activities to further cost containment objectives, but, as far as governmental regulation is concerned, only encourages participation in legislative debates over future health care system regulation without suggesting what positions should be taken. *Id.* at x.

190. *See* Berger & Earsy, *Occupations of Boston Hospital Board Members*, 10 INQUIRY 42 (1973).

sociated with wages paid to labor.[191]

The elderly, who are increasingly better organized for advocacy purposes, may have the least ambivalence about supporting hospital cost containment activities. Yet, the needs of the elderly relate to so many areas of society and the economy that organized groups representing their interests must continuously establish their priorities, with many other matters competing with hospital issues for attention. Indeed, in the health field alone, organizations of the elderly are also concerned with such issues as enhancing the quality of care in long-term care facilities and expanding community-based health services. To the extent hospitals represent a major source for expanding community-based services, such groups may be reluctant to take strong antihospital positions.[192]

The pressure on Blue Cross to control premium increases has clearly had the effect, at least in Massachusetts, of moving it away from the very close relationship with hospitals that has been a source of past criticism.[193] Nevertheless, to the extent that Blue Cross' interest in cost containment is a function of marketing concerns, it may be expected to be as ambivalent toward governmental cost containment regulation as the large employers or employee groups that represent its principal purchasers.

In addition, Blue Cross has other constraints on its capacity to take an active role in this area. For example, Blue Cross in Massachusetts relies on voluntary contractual arrangements with hospitals for determining the terms and conditions of its payment on behalf of subscribers and for allowing it to pay hospitals on the basis of costs when costs are

191. The 1977 Cost Containment Act proposed by the Carter Administration contained an exemption from controls for wages and salaries of non-supervisory employees. H.R. 6575, 95th Cong., 1st Sess. § 124 (1977); S. 1391, 95th Cong., 1st Sess. § 124 (1977). The 1979 version of the proposed Cost Containment Act carries forward the proposal for such an exemption. *See* S. 570, 96th Cong., 1st Sess. §§ 2(b)(2), 2(c)(1)(A)(ii), 7(a)(1)(A). *See also* Mass. Hospital Workers Local 880, Elements Necessary for Local 880 to Support Hospital Controls (Unpublished position paper Feb. 15, 1976).

192. Expansion of community-based services by hospitals may be expected to occur in outpatient areas. It is significant in this context to note that the proposed Hospital Cost Containment Acts introduced by the Carter Administration into the 95th and 96th Congresses have consistently exempted hospital outpatient revenues from control. *See* H.R. 6575, 95th Cong., 1st Sess. (1977); S. 1391, 95th Cong., 1st Sess. (1977).

193. *See, e.g.*, S. LAW, BLUE CROSS: WHAT WENT WRONG? 25-30 (1974). The corporate bylaws of Blue Cross of Massachusetts, Inc., provide that no more than five of the one hundred corporate members be "providers of health care or organizations representing such providers." By-Laws, Massachusetts Blue Cross, Inc. (November 1, 1972). The contract negotiated between Blue Cross and the Massachusetts Hospital Association in 1972-1973, HA-25-TH, represents one of the most progressive and cost containment-oriented Blue Cross agreements in the country. Five hospitals in the state initially refused to sign the agreement because of its provisions.

lower than charges.[194] Despite possible economic hardship, it is possible for hospitals to survive financially without a Blue Cross contract.[195] Thus, the harder Blue Cross tries to use the contract for cost containment purposes, or the more aggressively Blue Cross supports governmental cost containment programs, the more likely it is that hospitals may refuse to enter into contracts with Blue Cross.[196] In that situation, Blue Cross in Massachusetts is for all practical purposes bound to pay full charges.[197] It thereby loses some of its competitive advantage over commercial insurers, who would ordinarily make payments at charges, not the lower of costs or charges.

Unlike Blue Cross, commercial insurers do not rely on a contractual relationship with hospitals to determine the terms and conditions of payment. These insurers generally make payment based on hospital charges, which may or may not be related to the cost of providing services. When charges are higher than costs,[198] commercial insurers may be at a competitive disadvantage compared with Blue Cross, which under such circumstances will make payment based on cost. As a result, these insurers have a strong incentive to support those cost containment programs that call for regulating charges by relating them to definitions of allowable cost. Indeed, in order to eliminate the automatic differential that operates in favor of Blue Cross in most states, commercial insurers have made strenuous efforts to encourage the development of charge control programs that also provide for uniform rates for all purchasers.[199]

194. *See* MASS. STAT. ANN. ch. 176A, § 5 (Law. Co-op 1977).

195. *See* letter to Stephen M. Weiner, Special Assistant to the Governor, from Henry D. Jones, President, Blue Cross of Massachusetts, Inc. (Aug. 9, 1973); RSC HA-27 Statement (1977), *supra* note 24, at 3.

196. *See* RSC HA-27 Statement (1977), *supra* note 24, at 2-3.

197. *See* Massachusetts *ex rel.* Massachusetts Blue Cross, Inc. v. Mercy Hosp., No. 72-150 (Mass. Sup. Ct., November 13, 1972).

198. Charges may be higher than "cost" where a particular purchaser employs a restrictive definition of cost, such as excluding an allowance for bad debt and free care; or when the hospital wishes to build in a financial cushion or surplus. For examples of differences in cost definitions, see note 170 *supra*.

199. The Health Insurance Association of America (HIAA) sought hospital charge control legislation in Massachusetts as early as 1972. *See* S. No. 875 (1972); letter from Harold Hestnes to Hon. Robert L. Yasi, Secretary of Administration and Finance, Commonwealth of Massachusetts (Feb. 25, 1972). In 1977, funded primarily by the private insurance carriers, Government Research Corporation of Washington, D.C., developed through a task force a model bill for state-level ratesetting programs. *See* Statement of Robert D. Kilpatrick, President and Chief Executive Officer, Connecticut General Insurance Corporation, on the Hospital Cost Containment Act of 1977, delivered to Subcommittee on Health of the Senate Human Resources Committee, June 21, 1977. The model bill provided the basis for a legislative proposal announced by Senator Schweiker as an alternative to the Administration's Hospital Cost Containment Act. *See* 123 CONG. REC. E4220-21 (daily ed. July 1, 1977).

On the other hand, because of the absence of traditional relations with hospitals, the commercial insurers have had less involvement historically than Blue Cross in health policy development. Further, because most of them market other lines of insurance, their political attention must be directed to a number of issues simultaneously, which dilutes their capacity to provide effective political support to hospital cost containment efforts specifically.

This survey of the major potential cost control constituencies suggests that the state, in seeking to develop allies in its policy objectives, may find relatively little strong and consistent support for government cost containment initiatives. The state's position of relative isolation is further complicated when one considers an additional political characteristic of the hospital system—the status of hospitals themselves.

3. The Status of Hospitals

Virtually all of the acute care general hospitals in Massachusetts are nonprofit institutions.[200] They enjoy the respect normally accorded charitable organizations. Further, most of the state's acute care general hospitals, with the possible exception of some of the major teaching institutions, are strongly identified with the communities in which they are located or to which they provide services.[201] This community identification is even stronger in nonprofit hospitals located away from large urban areas.[202] The local citizens view the hospital as "theirs"; there is a strong pattern of relationships with the facility, generally dating back for some period of time, and there is a sense of "pride" associated with having ready access to hospital services.

Most importantly, perhaps, the trustees of such hospitals are generally drawn from the dominant social and economic strata of the community.[203] This has two beneficial effects for the hospital. First, the hospital may, as a result and with some reason, argue that its board understands the community needs, and those needs will therefore be adequately represented in internal hospital decisions with respect to prices and services. This argument easily becomes intertwined with the view, produced by the usual tension between small local communities

200. Of the 122 acute hospitals listed in the MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH, HEALTH DATA ANNUAL (1976), it is estimated that only ten were proprietary. Of that group, three ceased to function as acute hospitals after 1976.

201. BOSTON GLOBE, Jan. 31, 1979, at 1, col. 1 (discussing responses of citizens of small towns to perceived threat to local hospitals contained in draft state health plan).

202. *Id.*

203. *See* Berger & Earsy, *supra* note 190.

and state government, that the large "insensitive" state bureaucracy does not adequately understand the local scene and should not try to impose its view on the community.[204] Second, the board provides a strong base from which hospitals may, individually or collectively, develop and exert political influence, especially on local state legislators.

The favored status of the individual community-based hospital is not necessarily diminished by generalized political and social concerns about cost containment. As discussed earlier, the direct impact of the cost increases incurred by a particular hospital is usually diffused through tax and insurance mechanisms,[205] so that the community using the services of the hospital does not ordinarily feel directly the added financial burden placed on the health system by the institution's specific cost increasing decisions. Thus, while cost containment as an abstract concept may be supported by members of the community, it is a very different matter when an individual state cost containment decision has an adverse impact on the community's hospital, as opposed to hospitals generally.

V. Strategies to Support Hospital Cost Containment Regulatory Agencies

The preceding sections indicate some of the difficulties that confront "reformist" hospital cost regulatory agencies. Structural characteristics of the hospital service industry deprive the agencies of readily available "natural" constituencies to provide political support for their objectives. Further, the availability of procedural mechanisms by which segments of the public may participate in the agencies' decisional processes has not provided a vehicle for the agencies to develop political understanding of and support for their policies.

These difficulties that attend the functioning of "reformist" agencies raise the likelihood that they will evolve into "reluctant" ones as lack of a strong, supportive political constituency undercuts the willingness of the agencies to attempt substantial reform of the hospital industry. Indeed, perhaps the only factor that may retard such an evolution is the continuing budgetary concern of the government,[206] which may be expected to support strong containment efforts by the regulatory agencies.

204. *See* Boston Globe, Jan. 31, 1979, at 1, col. 1.

205. *See* text accompanying notes 178-199 *supra.*

206. *See* text accompanying notes 163-177 *supra.*

Is such an evolution inevitable, however? The question is obviously an important one, both to the agencies currently engaged in hospital cost regulatory activities and to policy analysts who support increased governmental action to shrink the size of the existing hospital system. Asked another way, are strategies available that the agencies may pursue to build political support for their reformist objectives?[207]

Two approaches, at least, represent possibilities for building such support. Neither, however, provides any high degree of certainty of success. The first encompasses an intensive educational outreach effort by the agencies, the purpose of which is (a) to develop an understanding among different constituency groups of the relationship between the agencies' objectives and the group's particular conerns, (b) to seek a set of common understandings and objectives that may be reflected in the agencies' operations, and (c) to convert the educational activities into ongoing relationships that can be translated into political support for the common objectives. The second strategy involves developing a formal linkage between the agencies' regulatory activities on the one hand, and on the other, processes that may be viewed as having similar objectives but that necessarily involve a broader diversity of views than those represented in the agencies' activities. Of particular interest for linkage with regulatory activities are the planning and review responsibilities imposed on health systems agencies and state health planning and development agencies under the National Health Planning and Resources Development Act of 1974.[208]

A. Educational Outreach Efforts

This strategy proceeds from the view that if interest groups do not come to the agency, that is, are not generally willing to participate in the formal[209] agency proceedings intended to invite broad public participation, then the agency must go to the interest groups. Ordinarily, such a strategy is more characteristic of legislative lobbying efforts on

207. The types of strategies considered here are not the more traditional ones involving efforts by the agency to increase the amount of personnel and budgetary resources made available to it. *See, e.g.*, B. SMITH, LIVING WITH CIVIL SERVICE: THE MASSACHUSETTS EXPERIENCE (1976). Nor do they encompass efforts to restructure agency process to permit more effective interest group participation, an issue discussed in the text accompanying notes 1-11 *supra*.

208. National Health Planning and Resources Development Act of 1974, Pub. L. No. 93-641, 88 Stat. 2225 (1975) (codified at 42 U.S.C. §§ 300k, 300t (1976)).

209. For purposes of this discussion the term "formal" is not used in the sense of the federal Administrative Procedures Act concept of formal rulemaking or adjudication as distinct from informal rulemaking. Instead, it is intended to distinguish agency action as required by statute, such as public notice and comment, from other kinds of agency actions.

behalf of an agency. For example, the Dukakis Administration in Massachusetts undertook extensive educational efforts in 1975 and 1976, particularly with business, labor and elderly groups, to explain the importance of the proposed Hospital Cost Containment Bill that culminated in Chapter 409.[210] Similar efforts have been undertaken by the Carter Administration nationally in 1979 in support of its proposed Hospital Cost Containment Act.[211]

Such outreach efforts, consciously aimed at developing public/political support for an agency's position, are relatively rare at the level of administrative, as opposed to legislative, activities. One example, however, is the so-called generic process used in developing standards and criteria for the Massachusetts DON program.[212] The process involves extensive consultation among interested and knowledgeable parties aimed at developing standards and criteria to be embodied in regulations governing treatment of projects proposed under the DON program. The DPH does not undertake the consultative process with a detailed product already developed, but instead makes use of the common objective of the parties and the value placed on developing acceptable cost containment-oriented rules as the parameters of the process. The consultative process itself shapes the final product, which takes the form of recommendations for proposed DPH regulations.

At least theoretically, the DPH's use of the generic process enables it to make participating groups aware of its values and objectives. At the same time, participation by the various groups themselves may commit them politically to the end result, even if any one of them alone, including the DPH, would not have been independently willing to accept the product. By entering into the process, the DPH or another regulatory agency has the opportunity to shape the results of its policy goals, but at the same time, and in exchange for that, it must recognize that, to a large extent, it gives up its ability to determine the precise details of the resulting recommendations. Just as the participant groups are psychologically committed to the result, if the process is sensitively handled, so is the agency committed to it as well.

The generic process is organized around specific products. One can envision a variant of this educational strategy that does not necessarily produce a set of recommendations for proposed regulations, but

210. *See* background documents and strategy papers concerning efforts to enact H. 3160, in the personal files of the author.

211. *See, e.g.*, HEALTH REGULATION LETTER, March 10, 1979, at 1-2.

212. *See* Massachusetts Dep't of Public Health, Draft State Health Plan §§ 1.15-1.16 (1978).

instead allows for an informal and ongoing sharing of views and objectives by diverse sets of groups, all of which are affected by the agency's responsibilities. Three characteristics mark this kind of process: informality, continuity and focus on the agency's general programmatic activities, not on a specific product.[213] Such a process permits the agency to explicate its policies and objectives in a more discursive fashion than generally attends agency statements in formal administrative procedures. It thereby provides a forum in which the agency can develop understanding for its positions among the participating groups. At the same time, such a continuing interchange would permit the other participants to educate the agency about their attitudes and positions in a more detailed fashion than might ordinarily be available in formal procedures. The agency might thereby better understand the impact of its activities on various affected groups, an impact that might not be readily discernable in formal statements prepared by representatives of the various groups for presentation at public hearings.[214] With such an understanding, the agency would be more likely to consider alternative methods of achieving its objectives.

While the educational approach represents one strategy available to a reformist agency, use of it raises a number of problems. Three are particularly important. First, none of the possible variants of this model precludes co-option of the agency by dominant industry interests, which are presumably entitled to participation. Certain factors, however, may impede such a result. First, participation would be open to more than just the agency and the regulated industry. Other groups, the interests of which are not necessarily consistent with the industry's, would be included. In either a task-specific or an ongoing relationship, this diversity of participation should serve as a countervailing force to the industry's position. Second, it may be expected that co-option occurs when the agency either willingly or passively accepts such a result. The agency's participation in the educational outreach strategy, however, is intended specifically to avoid such a result and to develop sup-

213. An example of one type within this model is the Maryland Health Care Coalition, largely inspired by the Health Insurance Association of American (HIAA), in which the Maryland Health Services Costs Review Commission participates. *See* Health Insurance Association of America, Goals and Objectives of the Maryland Health Care Consortium (1978).

214. The model envisioned is different from an advisory council structure in that (a) it is not officially established by a statute or formal agency action and (b) participation by various interest groups is more active, with more individuals from each group involved than is typically the case with advisory groups. Further, advisory boards typically function to provide advice to the agency but not necessarily to communicate agency positions to the constituent parties. The model described in effect functions in the first place to communicate information from the agency to private groups.

port for the agency in its regulatory relations with the industry. In a sense, then, an agency willing to enter into such a strategy will already be conscious of efforts to co-opt it and can develop countervailing tactics to prevent co-option from occurring.

Second, the educational outreach strategy may render formal public notice and comment processes irrelevant or meaningless. Major policies may be agreed upon and, in the case of the DON generic process, specific regulatory provisions may be worked out in some detail prior to promulgation of proposed regulations. The extent to which informal activities undercut the meaningfulness of formal agency actions is necessarily a matter of some concern. As a result of this concern, new types of public notice have been developed, such as the notice of intent to issue proposed regulations, evidencing an effort to move the possibility for public participation back into earlier stages of the agency's policy development process than may have ordinarily occurred under standard APA notice requirements. Further, the educational outreach strategy, which is initiated by the agency, does not necessarily involve all the parties that might respond to a public notice. Indeed, to the extent the agency attempts to target particular politically influential groups for inclusion in the educational process, the strategy is likely to encompass participation by a relatively small segment of the available spectrum of interests. Yet if common agreement on policy and objectives emerges from processes like the DON generic process described earlier, then the decision concerning inclusion or exclusion of certain interests could effectively foreclose the excluded parties from any meaningful participation at any stage of the policy development process, up through the stage of formal adoption. The agency may thereby gain political support at the expense of traditional notions of public accountability and participation. Even though there may be no extensive public participation in the agency's formal procedures,[215] the possibility that such participation can occur and have an impact is an important principle to retain.

Third, the idea of an agency initiating efforts to gain public and political support for its policies is not one envisioned by traditional legal models of the administrative agency. These models tend generally to derive from considerations of the legitimacy of administrative actions.[216] Legitimacy may attach to agency action to the extent the ac-

215. *See* text accompanying notes 86 & 87 *supra*.

216. For a discussion of the legitimacy of actions by administrative agencies, see J. FREEDMAN, CRISIS AND LEGITIMACY 259-266 (1978).

tion can be seen as clearly following from a legislative policy,[217] or as involving application of objective expertise to a particular set of factual circumstances,[218] or as representing a conception of a public interest developed from a balancing by the agency of conflicting and competing interests. The models, based on these sources of legitimacy, have a common characteristic in that they appear to assume a passive agency having as its only interest the performance of its delegated responsibilities. A reformist agency undertaking an educational outreach strategy, however, is assumed to be an activist agency attempting to build support for its position. The position taken presumably derives from an interpretation of the agency's legislative authority, and therefore is one the agency can legally—even if not necessarily politically—sustain. Thus, the DPH or the RSC, in administering DON or Chapter 409, could undertake an outreach strategy without having questions raised about the policies it is pursuing. But an agency seeking cost containment objectives in the absence of a defined legislative mandate—such as if one of the Massachusetts agencies were to undertake a shrinkage strategy under current statutory provisions[219]—might face not only strictly legal questions concerning the scope of its authority, but questions concerning the very legitimacy of the agency's conduct. In pursuing an educational outreach strategy in the absence of relatively clear statutory policy, the agency is in effect going beyond the conception of agency action embodied in traditional doctrines. A significant issue requiring further exploration is what theory of legitimacy would support the agency under such circumstances.[220]

B. The Planning Strategy

An alternative strategy that allows the agency to retain a passive role while developing support for its positions is to build upon the planning and review activities undertaken under the National Health Planning and Resources Development Act of 1974. This federal legislation establishes two planning bodies within a state that, in their composition, reflect the varied interest groups within the health system: the health systems agency (HSA) and the statewide health coordinating

217. For an analysis of this concept, see Stewart, *supra* note 2, at 1672-76.

218. *Id.* at 1677-78.

219. *See* note 29 and accompanying text *supra*.

220. Relatively little rigorous analysis has been undertaken of the concept of agency legitimacy. An excellent example of this limited literature is J. FREEDMAN, *supra* note 216.

council (SHCC).[221] The HSA is responsible for developing the health systems plan (HSP) for its area, and the annual implementation plan (AIP) aimed at achieving the goals of the HSP.[222] It also reviews and provides recommendations on such matters as applications from the area for various federal funds,[223] the appropriateness of institutional services provided within the area[224] and applications for certificates of need emanating from institutional providers within the area.[225] While not specifically required as yet, it may be expected that review activities undertaken by an HSA will eventually be based on standards derived from the area HSP and AIP.

The SHCC is responsible for adopting a state health plan (SHP), which is made up from the area HSPs with adjustments for differences arising from a statewide perspective.[226] Again, while not yet specifically required by federal statute, the SHP may eventually provide the basis for standards applicable in the administration of statewide appropriateness review or certificate of need processes by the state health planning and development agency.[227]

Two characteristics of the National Health Planning and Resources Development Act of 1974 suggest that the process of developing the HSP and SHP is intended to be a consensual one. First are the requirements concerning composition of the boards of the HSAs and of the SHCC.[228] Membership is prescribed to reflect and balance the di-

221. National Health Planning and Resources Development Act of 1974, Pub. L. No. 93-641, §§ 1512, 1513, 1524, 88 Stat. 2234 (codified at 42 U.S.C. §§ 300*l*-1, -2, 300m-3 (1976)).

222. *Id.* § 1513(b)(2), (3) (codified at 42 U.S.C. § 300*l*-2(b)(2), (3) (1976)).

223. *Id.* § 1513(e) (codified at 42 U.S.C. § 300*l*-2(e) (1976)).

224. *Id.* § 1513(g) (codified at 42 U.S.C. § 300*l*-2(g) (1976)).

225. *Id.* § 1513(f) (codified at 42 U.S.C. § 300*l*-2(f) (1976)).

226. *Id.* § 1524(c)(2) (codified at 42 U.S.C. § 300m-3(c) (1976)).

227. One version of the proposed amendments to the National Health Planning and Resources Development Act of 1974 introduced into the first session of the 96th Congress, calls for requiring that certificate of need decisions "shall not be inconsistent with the State health plan." *See* proposed section 1527(a)(6) of Title XV of the Public Health Service Act, H.R. 3041, 96th Cong., 1st Sess. (1979).

228. The Act provides for the following membership on the governing board and executive committee, if any, of an HSA:

> (i) A majority (but not more than 60 per centum of the members) shall be residents of the health service area served by the entity who are consumers of health care and who are not (nor within the twelve months preceding appointment have been) providers of health care and who are broadly representative of the social, economic, linguistic and racial populations, geographic areas of the health service area, and major purchasers of health care.
>
> (ii) The remainder of the members shall be residents of the health service area served by the agency who are providers of health care and who represent (I) physicians (particularly practicing physicians), dentists, nurses, and other health professionals, (II) health care institutions (particularly hospitals, long-term care facilities, and health main-

versity of interests in the health system. Almost as a matter of necessity, agreement upon an HSP or SHP from such an organizational structure must come from a process of negotiation and accommodation. A final product depends on development of a block representing a majority of the members, not a single decisionmaker. But the credibility of the process—that is, the willingness of all the requisite parties to participate in it—turns on each party being satisfied to some extent with the accommodation.

The second characteristic is that there is no direct authority for the

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tenance organizations), (III) health care insurers, (IV) health professional schools, and (V) the allied health professions. Not less than one-third of the providers of health care who are members of the governing body or executive committee of a health systems agency shall be direct providers of health care (as described in section 1531(3)).

(iii) The membership shall—

(I) include (either through consumer or provider members) public elected officials and other representatives of governmental authorities in the agency's health service area and representatives of public and private agencies in the area concerned with health,

(II) include a percentage of individuals who reside in nonmetropolitan areas within the health service area which percentage is equal to the percentage of residents of the area who reside in nonmetropolitan areas, and

(III) if the health systems agency serves an area in which there is located one or more hospitals or other health care facilities of the Veterans' Administration, include, as an ex officio member, an individual whom the Chief Medical Director of the Veterans' Administration shall have designated for such purpose, and if the agency serves an area in which there is located one or more qualified health maintenance organizations (within the meaning of section 1310), include at least one member who is representative of such organizations.

42 U.S.C. § 300*l*-1(b)(3)(C) (1976). The Act provides for the following membership on the SHCC:

(A) (i) A SHCC shall have no fewer than sixteen representatives appointed by the Governor of the State from lists of at least five nominees submitted to the Governor by each of the health systems agencies designated for health service areas which fall, in whole or in part, within the State.

"(ii) Each such health systems agency shall be entitled to the same number of representatives on the SHCC.

"(iii) Each such health systems agency shall be entitled to at least two representatives on the SHCC. Of the representatives of a health systems agency, not less than one-half shall be individuals who are consumers of health care and who are not providers of health care.

"(B) In addition to the appointments made under subparagraph (A) the Governor of the State may appoint such persons (including State officials, public elected officials, and other representatives of governmental authorities within the State) to serve on the SHCC as he deems appropriate; except that (i) the number of persons appointed to the SHCC under this subparagraph may not exceed 40 per centum of the total membership of the SHCC, and (ii) a majority of the persons appointed by the Governor shall be consumers of health care who are not also providers of health care.

"(C) Not less than one-third of the providers of health care who are members of a SHCC shall be direct providers of health care (as described in section 1531(3)).

"(D) Where two or more hospitals or other health care facilities of the Veterans' Administration are located in a State, the SHCC shall, in addition to the appointed members, include, as an ex officio member, an individual whom the Chief Medical Director of the Veterans' Administration shall have designated as a representative of such facilities."

Id. § 300*l*-2(c) (1976).

HSAs or the SHCC to implement the plans. The only specific reference in the Act to a plan implementation strategy involves recourse to persuasion and the use of technical assistance and developmental funding.[229] As was noted earlier, there is no requirement that the plans provide the basis for recommendations or findings on the appropriateness of existing institutional services or the need for new institutional services.[230]

These two characteristics, taken together, suggest the logic of combining the planning and regulatory processes, so that the plans provide the policy basis for regulatory decisions.[231] While there are clearly logistical and philosophical difficulties associated with such a linkage,[232] there would be significant advantages to the regulatory agencies from such an arrangement. First, the goals and objectives of the planning process, as established in the Act and such documents as the National

229. The Act provides the following with respect to implementing HSPs and AIPs:

> (1) The agency shall seek, to the extent practicable, to implement its HSP and AIP with the assistance of individuals and public and private entities in its health service area.
>
> (2) The agency may provide, in accordance with the priorities established in the AIP, technical assistance to individuals and public and private entities for the development of projects and programs which the agency determines are necessary to achieve the health systems described in the HSP . . .
>
> (3) The agency shall, in accordance with the priorities established in the AIP, make grants to public and nonprofit private entities and enter into contracts with individuals and public and nonprofit private entities to assist them in planning and developing projects and programs which the agency determines are necessary for the achievement of the health systems described in the HSP. Such grants and contracts shall be made from the Area Health Services Development Fund of the agency established with funds provided under grants made under section 1640. . . .

42 U.S.C. § 300*l*-2(c) (1976).

230. This distinction between the project review responsibilities of HSAs, either through appropriateness review or review of new institutional services, and the goals and objectives of the HSPs and AIPs is implicitly recognized in DHEW regulations governing reviews by state health planning agencies with respect to certificates of need for new institutional services. 42 C.F.R. § 123.407(a) (9) (1978) requires the state agency to provide to the HSA "a written detailed statement" of the reasons why its decision regarding a proposed new institutional health services is inconsistent "with a *recommendation made with respect thereto* by the health systems agency making such recommendation." (Emphasis added.) The regulation further provides that if the state agency "makes a decision regarding a proposed new institutional health service which the State Agency determines *is not consistent with the goals of the applicable health systems plan . . . or the priorities of the applicable annual implementation plan*," the agency is again required to submit a "written, detailed statement of the reasons for the inconsistency." *Id.* § 123.407(a) (11) (emphasis added).

The separation of these two provisions implies that the recommendation of the HSA with respect to a certificate of need application itself need not be consistent with the HSA's own HSP or AIP.

231. *See generally* K. BAUER, THE ARRANGED MARRIAGE OF HEALTH PLANNING AND REGULATION FOR COST CONTAINMENT UNDER P. L. 93-641 — SOME ISSUES TO BE FACED (1977); Weiner, *supra* note 29.

232. *See* Weiner, *supra* note 29, at 57-63.

Guidelines for Health Planning,[233] are compatible with the objectives of the cost containment regulatory agencies. The overview contained in the Supplemental Information accompanying the National Guidelines, for example, stresses the importance of cost containment as a prerequisite for achieving other goals in the health delivery system.[234] Second, the development of the plans occurs through a structured, community-based, and broadly participatory process, at both the area and state levels, involving public hearings and decisions by representative groups. The types of interest that ought to participate in the formal regulatory proceedings participate in the plan development process. Because of the consensual nature of the process, it may be expected, as suggested earlier, that the participants will be more committed to the end-product than they would be if the same product emerged from a formal regulatory proceeding.

Consequently, were the regulatory agencies to adopt the goals and policies of the planning documents as the basis for their decisions, there would be a high likelihood that the same groups who participate in the development process would support the agency's decisions. To the extent that the plans were themselves converted into institution-specific recommendations and findings through the AIP, certificate of need or appropriateness reviews, adoption of these recommendations and findings as regulatory decisions would also presumably enhance the acceptability of those decisions.

Despite the political advantages to the regulatory agencies of linking planning with regulation, there are some pitfalls. First, there are logistical problems of administrative law associated with translating the plans and institution-specific recommendations into regulatory decisions, although most of the problems appear capable of resolution.[235] Second, there is no assurance that the plan development process will actually be free of dominant industry influence, despite the minority status of providers on the HSA board and on the SHCC. While at least one recent study has suggested that the anticipated co-option of HSAs may not be occurring, it ascribes the result at least in part to HEW's insistence on evaluating HSAs from the perspective of cost containment concerns.[236] There may, however, be no structural characteristics

233. 42 C.F.R. pt. 121 (1978).

234. 43 Fed. Reg. 13,040 (1978).

235. *See* text accompanying notes 231-34 *supra.*

236. *See* Sapolsky, Altman & Greene, Assessing the Health Planning Experiences Under P. L. 93-641 9-10, 20 (1978) (unpublished paper on file in the office of the *North Carolina Law Review).*

preventing provider dominance. At the least, regulatory agencies adopting the planning strategy must carefully assess the extent to which HSAs and the SHCC are pursuing objectives compatible with the interests of the agencies.[237]

Third, incorporation of planning outcomes into regulatory decisions may affect the consensual nature of the planning process. The capacity of the HSAs and the SHCC to develop consensus on plans may in large part be due to the very absence of direct means of implementing the policies of the planning documents. Linking planning and regulation may increase the stakes associated with participation, particularly for providers, and may make providers far less willing to cooperate in plan development. Such an occurrence would undermine the consensual nature of the process—the major value of planning as a means of providing support to regulatory decisions.

The strategy of linking planning and regulation may be of significant advantage to the cost containment regulatory agencies seeking public and political support for their decisions. Nevertheless, there may be difficulties, practical and theoretical, associated with the strategy that require extensive analysis before embarking on it. Since questions and difficulties are associated with both of the two major support-building strategies, however, it may be necessary for the agencies to undertake a certain amount of risk if they intend to continue acting as reformers of the regulated system.

237. The potential co-option of HSAs raises a difficult question of legitimacy. If a governmentally sanctioned and apparently democratic process is not capable of preventing one group or a relatively small number of groups from dominating the results of that process, what arguments support the greater legitimacy of a bureaucratic agency refusing to accept the values associated with the result and superimposing its own views on the process?