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Health System Oversight by States: An Environmental Scan

The high cost and uneven quality of healthcare have profound negative impacts on the health and financial security of American families. Unaffordable prices can lead consumers to delay or forgo needed medical care and cause painful budgetary tradeoffs, medical debt and bankruptcy.¹ Moreover, the quality of care that patients receive does not uniformly reflect our high healthcare spending.

States are under financial pressure to prioritize and promote health system efficiency to manage their budgets, attract employers and to address the healthcare affordability concerns of their residents.² While all states have well-defined roles for certain segments of their health

system—such as Medicaid, state employee coverage, healthcare delivered within the criminal justice system, and public health and safety-net coverage—relatively few states take a comprehensive, systematic approach to ensure that all consumers get value for the money they spend.

But there are exceptions: a few states such as Vermont, Colorado, Pennsylvania and others have oversight agencies focused on lowering spending, while increasing quality and access for their residents. This report compares state approaches to comprehensive health system oversight. Through this exercise, we hope to help states more effectively leverage this approach to reduce healthcare spending and improve quality.

SUMMARY

It's hard to imagine robust progress on healthcare value issues without an overarching entity whose role is to look at the big picture. And yet, to date, only a few states have a centralized oversight agency that focuses on reducing healthcare costs, improving quality, bringing spending in line with overall economic growth and implementing new innovations for better value.

This report is a comparison of broad healthcare oversight authorities in seven states. We found significant variation in the responsibilities and powers these entities hold. Common roles include recommending strategies to combat rising healthcare costs and monitoring aspects of healthcare quality. Less common roles include regulating health insurance rates, piloting new innovations and implementing global budgets.

By comparing these roles, we hope to help states more effectively leverage this approach to reduce healthcare spending and improve quality.

Why is an Oversight Authority Needed?

While there will always be a federal and private payer role, there are myriad reasons why much of the activity to successfully address poor healthcare value needs to occur at the state level.³

For one, our fragmented health system typically limits the ability of any one payer or stakeholder to incentivize the provider practice changes that will lead to lower costs.⁴ States are well positioned to serve as a convener and support the multi-payer coordination that is critical for meaningful progress on healthcare value.

Further, broad access to coverage and getting to better healthcare value are inseparable, intertwined policy objectives. State efforts to ensure access to coverage will be eased if the costs of care are more reasonable. In addition, efforts to improve the value we get for our healthcare dollar—such as provider payment reform—are universally premised on a population having coverage.

Moreover, state governments are uniquely positioned to invest in “upstream” approaches that lead to healthier communities. Research shows that just 10-20 percent

of health outcomes are determined by the medical care we buy.⁵ The majority is determined by socio-economic factors and health behaviors, with a smaller role for the physical environment.⁶ To improve population health, there is a growing recognition that we must invest in the modifiable social determinants of health like education, job development, housing and the environment.⁷ Getting to healthcare value requires a coordinated effort between these clinical and non-clinical settings. To reiterate, states have the incentive and capacity through health and social services agencies to facilitate this activity.

All of these activities could be more effectively accomplished if there is an entity empowered to look systematically across various types of health and social spending, with systems to identify where the state needs to be more efficient in terms of value for each dollar spent, quality short-comings and affordability problems for residents.

What is an Oversight Authority?

At a very general level, state oversight entities keep track of healthcare spending in a comprehensive and systematic way. They provide data and research support to the state and other stakeholders to track healthcare prices and provider quality to determine if state, employer and household resources are used efficiently.

While many states have experience establishing measures and setting priorities for population health, only a few states have agencies focused on and empowered to achieve the full triple aim for all their residents: improving the patient experience (including quality and satisfaction), improving the health of populations and reducing per capita costs.

This report describes the approaches of agencies in seven states (Table 1) and identified six major areas of responsibility that an oversight authority may find in its purview (Table 2).

Monitoring Healthcare Spending and Quality of Care

Six of the oversight agencies monitor spending in some or all of the major healthcare sectors (e.g., hospitals, insurance, and drug manufacturers). All seven oversight

Table 1
Agencies Reviewed for this Report

State	Oversight Agency	Acronym
Colorado	Colorado Commission on Affordable Healthcare	CCAHC
Maryland	Health Services Cost Review Commission	HSCRC
Massachusetts	Health Policy Commission & Center for Health Information and Analysis	HPC & CHIA
Oregon	Oregon Health Authority	OHA
Pennsylvania	Pennsylvania Cost Containment Council	PHC4
Vermont	Green Mountain Care Board	GMCB
Virginia	The Joint Commission on Healthcare	JCHC

authorities reviewed for this report focus on increasing the quality of care in their states. They all monitor quality trends and patterns in various healthcare environments and recommend policies that address disparities. Access to an all-payer claims database can be pivotal and operation of this valuable tool may be housed internally for some oversight authorities.

Hospital System Spending

All but one of the oversight entities examined hospital system expenditures—a large and increasing source of overall healthcare spending (Table 3).

One of the major duties for **Vermont's** Green Mountain Care Board (GMCB) is reviewing and establishing hospital budgets. The board uses financial and quality metrics to assess hospital performance, which culminates into written orders for each of Vermont's 14 hospitals. The orders include a trend target for financial growth as well as an overall cap on commercial rate increases.⁸ Working alongside other Vermont organizations, the GMCB also evaluates the quality of hospital care, patient outcomes and how those hospital outcomes are influenced by

Table 2
Potential Areas of Responsibility of Oversight Agencies

Category	Description
Monitor Spending	Many oversight agencies monitor spending in some or all of the major healthcare sectors (hospital, etc.). They may also seek to identify the underlying cost-drivers, such as unnecessary services, lifestyle factors and rising prices. Oversight authorities' abilities are greatly influenced by whether the state has an all-payer claims database.
Monitor Quality of Care/Disparities	Oversight authorities are often responsible for monitoring quality of care received in hospitals and other settings, as well as assessing disparities in health outcomes between populations.
Recommendations	All oversight authorities examined here have the power to make policy recommendations and present their findings about costs and quality in an annual report to their state legislature to increase transparency.
Health Insurance	A few oversight authorities incorporate a dimension of health insurance review into their work. These duties range from monitoring consumer access to insurance rates, health insurance rate review and the impact of mandated benefits on insurance plans.
Pilots/Innovations	A few oversight authorities are responsible for pilots and innovations designed to inform the path towards healthcare value, including overseeing the State Innovation Model grants provided by CMS.
Aggregate Purchasing Power	States can aggregate the health spending programs they administer or align payers in support of a high-performing health system. Oversight agencies can potentially oversee the coordination effort that would be needed.
Enforcement	Some oversight agencies go beyond data and recommendations, with power to subpoena, convene stakeholders or enforce global budgets.

social determinants of health. New healthcare expansion projects must obtain a Certificate of Need (CON) from the Green Mountain Care Board prior to implementation. The CON process is intended to prevent unnecessary duplication of healthcare facilities and services, guide their establishment in order to best serve public needs, promote cost containment, and ensure high quality healthcare.⁹

Health system oversight in **Massachusetts** is housed in two separate, but collaborating divisions. The state's Health Policy Commission (HPC) focuses on policy, while the Center for Health Information and Analysis (CHIA) focuses on research.¹⁰ For example, the HPC

releases an annual hospital budget policy and, in 2017, they lowered the benchmark based on statute to cut unnecessary spending, which the hospital association accepted. CHIA has documented wide variation in hospital prices, finding that a majority of spending was going to the most expensive hospitals.¹¹ Both Massachusetts entities report on the quality of hospital care as part of a systematic approach to measuring quality. CHIA uses a Standard Quality Measure Set that was developed by the state.¹²

Pennsylvania's Cost Containment Council releases a yearly report on hospital performance. The report assesses the quality of hospital services, including

Table 3: How State Oversight Bodies Compare

State Authority	Monitor Spending				Monitor Quality & Disparities	Develop Recommendations	Health Insurance Access to Coverage, Rates or Mandated Benefits	Oversee Innovations/ Pilots	Align Payers or Aggregate Purchasing Power	Powers	
	Hospital/ Hospital Systems	Rx Spending	Primary Care	APCD						Subpoena	Enforce State Goals (e.g., global budgets)
VT Green Mountain Care Board	X	X	X	X	X	X	X	X	X	X	X
MA Health Policy Commission	X	X	X	X	X	X			X	X	X
MA Center for Health Information and Analysis	X	X	X	X	X	X	X		X		
Oregon Health Authority	X	X	X	X	X	X	X	X	X		X
CO Commission on Affordable Health Care	X	X	X		X	X	X				
PA Cost Containment Council	X				X	X	X				X
MD Health Services Cost Review Commission	X		X		X	X					X
VA Joint Commission on Health Care					X	X					

hospital-specific information about common medical procedures and treatments patients receive. Included is information about case volumes, risk-adjusted measures of mortality and readmissions and adjusted average hospital charges.¹³

The **Oregon** Health Authority (OHA) reports the amount of state medical spending allocated to hospitals each year as a way to provide transparency and ensure public accountability for hospital expenditures.¹⁴ The authority is also in charge of certificate of need (CON) approval to any new hospital, skilled nursing or intermediate care service facilities.¹⁵ OHA publishes an annual quality performance report on all 28 Oregon hospitals that looks at 11 measures of quality, and compares hospitals to a benchmark. The measures are categorized by healthcare-associated infections, medication safety, patient experience, readmissions, behavioral health and ED information.¹⁶

The **Colorado** Commission on Affordable Healthcare operated from 2014-2017.¹⁷ During this time the commission focused on hospital spending related to utilization, low-value care, insurance rates and medical specialties, and used the data to make recommendations that address inefficiency in state hospitals.

Maryland's Health Services Cost Review Commission (HSCRC) monitors the efficiency and effectiveness of hospitals using financial data (revenue, expenditures and utilization), to inform the commission's recommendations on global hospital spending targets, uncompensated care and community benefits.¹⁸ The commission also reviews hospital projects through the certificate of need process, which measures how cost-effective the project is in meeting identified needs and that they are of high quality.¹⁹ Maryland focuses on improving hospital quality through four incentive programs: the Quality-Based Reimbursement Program, the Maryland Hospital Acquired Conditions Program, the Readmission Reduction Incentive Program and Potentially Avoidable Utilization Savings.²⁰

While **Virginia's** commission does not examine hospital spending data, it does track the quality of hospital care, for example, palliative care.

Prescription Drug Spending

With concern over drug prices at an all-time high, some oversight authorities investigate which drugs are harming consumers financially and offer recommendations to address this problem.²¹

Vermont's Green Mountain Care Board, in collaboration with the Department of Vermont Health Access, identifies up to 15 prescription drugs for which the state spends significant healthcare dollars. If the cost of these drugs has increased by 50 percent or more over the past five years they communicate this information to the Attorney General and make the information public, to inform employers and consumers.²²

The **Colorado** commission performed extensive research on prescription drug spending and formulated recommendations on how to address this issue. Recommendations included increasing transparency of drug prices, importation of drugs and paving the way for increased use of biosimilars.²³

The **Massachusetts** Health Policy Commission uses data from the state's all-payer claims database to analyze average out-of-pocket expenses by drug. The HPC uses this spending data to make recommendations to address affordability and spending concerns.²⁴

The **Oregon** Health Authority has a drug use review committee that regularly evaluates and recommends a list of drugs to be included in the practitioner-managed prescription drug plan. The committee takes into account the safety of the drugs being considered, the ability of consumers to access the drugs and the cost of the drug.²⁵

Primary Care

Understanding the amount and impact of upstream investments in preventive care and/or addressing unmet social needs can be important for controlling healthcare spending.

The **Oregon** Health Authority (OHA) analyzes primary care information (in conjunction with hospital care) in order to strengthen Oregon's healthcare infrastructure. In addition to reporting, OHA convenes

a Primary Care Payment Reform Collaborative. The Collaborative provides strategies for supporting sustainable primary care payment reform, such as increasing investments in primary care through the use of value-based payment methods.²⁶

The Green Mountain Care Board convenes the Primary Care Advisory Group, which was established by **Vermont** legislature and is comprised of primary care clinicians. The group makes recommendations to reduce the administrative burdens faced by primary care providers, such as developing a uniform hospital discharge summary or standardizing prior authorization rules.²⁷

The **Massachusetts** Health Policy Commission is required to develop and implement standards of certification for patient-centered medical homes.²⁸ The standards complement existing local payment reform efforts, validate value-based care and promote investments in efficient, coordinated and high-quality primary care.²⁹

Colorado supported its residents in attaining meaningful access to primary care and specialty care services by disclosing possible statutory and regulatory changes that enable healthcare professionals to practice at the top of their scope of practice.³⁰ The commission studied primary care efforts currently underway in the state and published the results in a report to the General Assembly and the Division of Insurance. The commission recommended that the Division of Insurance study the Direct Primary Care model and identify any implementation barriers that may exist.³¹ The commission also focused on rural access issues by providing rural providers with service price comparison reports from Colorado's all-payer claims database, with the idea that price transparency might persuade these providers to lower their prices. They also supported providers practicing in rural and underserved areas by increasing funding and recommending policies, such as increasing payment rates and reducing debt load.³² The commission also planned to break down silos within state agencies, which would have increased support to Medicaid patients to address unmet social needs such as housing, job training and/or job placement.³³

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Maryland is in the process of redesigning its primary care model. The HSCRC is part of the primary care council and continues to be a stakeholder in ongoing discussions. As the All-Payer Model progression broadens to include providers and delivery systems beyond hospitals, the HSCRC has focused on coordinating workgroup efforts across state agencies.³⁴

All-Payer Claims Databases

An all-payer claims database (APCD)—multi-payer claims database—systematically collects medical claims, pharmacy claims, dental claims, provider files and eligibility from private and public payers.³⁵ APCDs support healthcare and payment reform initiatives by providing detail that enables states to understand cost, quality and utilization. They are an important tool for measuring progress over time and can be used to increase transparency in healthcare for consumers, purchasers and providers.³⁶

Responsibility for APCD oversight varies by state. Among the seven states analyzed, three house responsibility for the APCD in the oversight body, three house responsibility in another state agency and one state is currently in the process of implementing an APCD.

VHCURES is **Vermont's** APCD, operated by the Green Mountain Care Board. With the input of stakeholders and analysts, the GMCB works to improve the quality of the information in the database.³⁷ Originally comprised of commercial claims data, in 2011 the state introduced Medicaid data and in 2014, Medicare data.³⁸

The **Massachusetts** APCD is a comprehensive source of health claims data from public and private payers, operated by CHIA. CHIA works collaboratively with payers to improve data quality and comprehensiveness. The organization has specialized staff that normalizes data across payers to support cross-payer analyses.³⁹

Oregon established an All-Payer All-Claims Database (APAC) in 2009 as a tool to measure healthcare costs, quality and utilization. The legislature commissioned the Oregon Health Authority to operate the database.⁴⁰

Colorado, Maryland and **Virginia** also have all-payer claims databases but they are operated by different agencies/organizations in their respective states. The **Pennsylvania** Cost Containment Council has a strong interest in creating a database sometime either in 2017 or 2018.

Legislative Recommendations

An essential role for oversight authorities is to provide state legislatures with valid research and recommendations that move the state towards greater healthcare value. All oversight authorities release annual reports highlighting their research and present recommendations to their state's general assembly. The impact of these recommendations varies depending on many factors, including possible enforcement powers discussed below.

Health Coverage

As noted above, broad access to coverage and getting to better healthcare value are inseparable, intertwined policy objectives. The evidence is clear that poor coverage limits healthcare access, and poor access is closely associated with poor health outcomes.⁴¹ Systematic approaches to better healthcare value must factor in access to health insurance coverage, yet—with only a few exceptions—coverage issues are rarely addressed by our seven state oversight agencies.

Access to Coverage and Insurance Rates

All states have an insurance department overseeing the health insurance market, as well as separate departments overseeing Medicaid. As a result, few of the oversight bodies described here are responsible for focusing on access to coverage. The main exception is CHIA, which monitors overall rates of health insurance coverage and out-of-pocket spending in **Massachusetts**, including commercial payers, MassHealth (Medicaid) and Medicare.⁴² This monitoring effort includes trends in premiums charged by health plans, including self-insured

employer plans, and how members utilize healthcare services in part to see if the health plan offerings are affordable and a good value.⁴³

Vermont's Green Mountain Care Board reviews health insurance rates and identifies the drivers of rate increases.⁴⁴ The Board annually reviews insurance plan design proposals from the state insurance marketplace, called Vermont Health Connect (VHC). VHC suggests standardized cost sharing designs for each metal level, which the Board reviews, then modifies or approves within 90 days of submission.⁴⁵ Insurers are required to offer these standard plans in the marketplace. In 2017, the board reviewed multiple rate filings and held public hearings on the state's individual and small-group market plans over a two day period, during which they also received more than 500 comments from residents. When combined with financial analysis, the board reduced the requested 2018 rate hike for the state's two largest insurers for the individual and small group market insurers.⁴⁶

The other oversight entities examined here occasionally collaborate with their state insurance departments. For example, the **Colorado** Commission on Affordable Care repurposed analyses conducted by the Colorado Division of Insurance for further studies and recommendations.⁴⁷ The **Oregon** Health Authority has a branch called Oregon Health Insurance Coverage that gathers coverage and access information to help make future policy recommendations regarding insurance.

Mandated Benefits

The **Pennsylvania** Healthcare Cost Containment Council (PHC4) reviews proposed mandated health benefits when requested by the Secretary of Health. PHC4 provides a preliminary review of the materials submitted by proponents and opponents of the proposed benefit to determine if the documentation is sufficient to proceed with the formal Mandated Benefits Review process.⁴⁸ The council then writes formal reports on the impact the mandated benefit would have on the affected population and the financial impacts for the state. **Massachusetts's** CHIA also reviews mandated benefits, providing guidance to the legislature for statewide policy decisions regarding health plan benefit levels.⁴⁹

Oversee Pilots/Innovations

Analyses of spending alone will not change a state's healthcare delivery or financing system. As described above, once spending hot spots or quality concerns are detected in the state's data systems or via patient feedback, states need a process for determining which approaches, if any, will fix the problem. Piloting new programs can help inform those decisions. Currently, few states empower their oversight entity to operate pilots but there are exceptions. For example, the **Massachusetts's** HPC is permitted to invest in community hospitals and promote the adoption of new delivery and payment models.⁵⁰

State Innovation Model (SIM)

The State Innovation Model (SIM) program was created by the Patient Protection and Affordable Care Act and is administered by the Center for Medicare & Medicaid Innovation. Each state-led model aims to achieve better quality of care, lower costs and improved health for their population. The initiative is testing the ability of state governments to use policy and regulatory levers to accelerate health system transformation.⁵¹

The Green Mountain Care Board played a central role in **Vermont's** multi-year, \$45 million SIM project known as the Vermont Healthcare Innovation Project (VHCIP).⁵² The project concluded in June 2017 and achieved four goals:

- 80 percent of Vermonters participate in alternative payment models from fee-for-service in 2017 (from 41% in 2013).
- For Vermont residents attributed to an ACO, the following population health goals will be realized: percentage with diabetes HbA1c Poor Control 20 percent or less; 70 percent or more with an abnormal BMI have a documented follow-up plan; and 85 percent or more identified as tobacco users receive a cessation intervention.
- Providers utilize the Vermont Health Information Exchange, a central repository of medical data that will improve the quality of care for patients.
- Cost savings reach \$45 million generated through payment reform models (which Vermont met in 2016).

The SIM grant in **Oregon** spurs innovation in several ways. It provides resources and technical assistance to Oregon's Coordinated Care Organizations by facilitating learning collaboration and rapid improvement cycles. Additionally, the project promotes health equity in four major policy areas: access to healthcare, affordable and safe housing and neighborhoods, employment opportunities and education opportunities.⁵³ The authority looks across various sectors including private payers, long-term care, community health and education systems.⁵⁴ It also evaluates methods for integrating and coordinating care between primary, specialty, behavioral and oral health providers. Finally, it aims to improve overall community health through health promotion and prevention activities.⁵⁵

Align Spending Across Payers

States can potentially aggregate the health spending programs they administer to support a high-performing health system. Vast amounts of state spending are tied up in the state's Medicaid, Children's Health Insurance Program, substance abuse treatment, mental health services, prison healthcare, and active and retired state government employee health insurance. In some states, this spending includes local government employees.⁵⁶ States with direct oversight of health insurance exchanges have yet another population potentially to coordinate with. Yet these spending efforts are typically housed in a variety of state agencies that lack the infrastructure to coordinate or conduct joint purchasing.

While states may make strategic purchasing decisions related to healthcare for state employees, retirees and dependents,⁵⁷ they have yet to use their combined state purchasing power in a meaningful way.⁵⁸ One exception: Oregon's legislation creating the Oregon Health Authority, which intended to consolidate the purchasing power of all public health benefits in a newly created entity.⁵⁹

On the other hand, states are helping to align public and private purchasing approaches through efforts that include:⁶⁰

- **Oregon's** health system transformation started with the creation of coordinated care organizations (CCOs), which serve Oregon Health Plan (or Medicaid)

members. The Oregon Health Authority is working to spread the coordinated care model to other plans and payers. The state received a CMS SIM grant to extend the model to Oregon residents who receive publicly funded health insurance starting with state employees and teachers, and subsequently to individuals and businesses purchasing qualified health plans on Cover Oregon, the health insurance marketplace. Eventually, the model might extend to those eligible for both Medicare and Medicaid, known as dual eligibles. The idea wasn't to create competition at the community level but to create regional incubators of innovation for payers to work together to solve problems in their community.⁶¹

- **Vermont** is taking a collaborative approach with a wide range of stakeholders to create a unified payment and delivery system. Stakeholders generally view the GMCB as leading the charge on payment and delivery system reform.⁶² In a recent example, the state received a CMS Medicare innovation agreement using an all-payer approach with ACOs. The GMCB, governor and the secretary of Agency of Human Services jointly negotiated the agreement.⁶³
- In **Massachusetts**, the public employee health purchasing entity and the Medicaid agency are aligning provider payment reform efforts. While the two bodies craft their requirements separately, they are each advancing common payment and delivery system reform approaches.⁶⁴ The HPC has a committee that focuses on payment systems and offers secondary support to these efforts.

Furthermore, a few states have undertaken efforts to align quality measures across multiple payers.⁶⁵ **Oregon's** 2013 law required a set of common quality measures to be used by the state's health insurance marketplace, the Oregon Health Authority (for the Medicaid population) and the state's teacher and public employee benefit boards. **Massachusetts's** 2010 law directed CHIA to develop a standard set of quality measures and requires uniform reporting of the measures by providers. The measure set is used by the state and by commercial health plans.

Other Powers: Convening, Subpoena & Enforcement

In the rare cases when an oversight entity has regulatory authority, this authority must be accompanied by some sort of enforcement mechanism. In addition to the rate review authority described above, three states have the ability to enforce global spending budgets. Subpoena and convening powers can also make it easier to accomplish the goals of the oversight entity, and are somewhat more common.

Convening Authority

Given the collaborative approach that several states are taking to work with other industry stakeholders, it is vital that oversight entities have the ability to convene stakeholders to further overall transformation aims. For example, **Oregon** can convene various advisory groups and a data review committee when necessary.⁶⁶ According to one industry observer, Oregon's convening authority is also useful as shield against antitrust concerns, providing an opportunity for collaborative engagement that may have a spillover effect on private sector purchasing and delivery.⁶⁷

Subpoena

A subpoena is a request for the production of documents—it essentially requires a person or entity to present information to help assess the facts or a case or policy issue. This useful power is rarely granted to health oversight entities, but our review found two exceptions. **Vermont's** Green Mountain Care Board, specifically the Chair of the Board, may issue subpoenas, examine persons, administer oaths and require production of papers and records.⁶⁸ **Massachusetts's** HPC can require testimony on healthcare cost trends from healthcare providers and payers.⁶⁹

Global Budget & Enforcement Authority

The **Vermont** Green Mountain Care Board, the **Massachusetts** Health Policy Commission, **Maryland's** Health Services Cost Review Commission, and the **Oregon** Health Authority are unique in that they have a

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wide scope of authority. An example of this authority is global budgets. One definition of a global budget is that it is a payment mechanism under which a single payment covers all healthcare costs for residents over a given period of time.⁷⁰ State oversight entities can play a key role in setting these global budgets and/or enforcing them.

Massachusetts has a statewide target for the rate of growth of total healthcare expenditures, called a healthcare cost benchmark.⁷¹ The Health Policy Commission is responsible for setting annual limits on healthcare cost growth among all providers and payers. For 2018-2022, the benchmark is equivalent to 0.5 percent less than the state economic growth rate—an effort to bend the cost curve over time. CHIA provides the HPC with an annual list of providers and payers whose cost growth, based on health status-adjusted total medical expense, is excessive, threatening the state's ability to meet its benchmark. The HPC has enforcement capabilities that can require certain providers to file and implement a performance improvement plan (PIP) when it identifies "significant concerns" about that provider's costs and determines that a PIP could result in meaningful, cost-saving reforms. The commission identifies the causes of and proposes strategies to reduce cost growth. The entity must carry out the PIP over the course of seventeen months, after which the HPC evaluates its success.⁷² We note that Massachusetts has not yet used this authority but might implement it in 2017 or 2018.⁷³

In 2016, **Vermont** obtained permission from CMS to set up an All-Payer ACO Model which provides that statewide spending growth for hospital and physician services will be contained to 3.5 percent, the state's economic growth. Currently, the participating ACO is reimbursing hospitals who join through a global budget.⁷⁴ The board will assume responsibility for implementing of the All-Payer ACO Model Agreement and ACO regulatory oversight.⁷⁵ In 2008, the HSCRC piloted a global budget

system for **Maryland** hospitals as an incentive to reduce unnecessary admissions and readmissions.⁷⁶ The 10 community provider hospitals that participated in the three-year Total Patient Revenue System pilot program received a fixed global budget covering all outpatient and inpatient services. The global budgets were based on the participating hospitals' revenue from the previous year, which was then adjusted by an estimate of underlying cost inflation, demographic changes in the hospitals' service areas and relative performance on specific quality measures.⁷⁷

Oregon has created a global budget for its Coordinated Care Organizations (CCO) so that provider payments and models will focus on the value, rather than the volume, of services provided. The OHA creates a CCO budget package that is then either passed or vetoed in the state's legislature. **Pennsylvania's** council provides research support in establishing global budgets for rural hospitals that choose to participate in the state's new initiative.⁷⁸

Governance and Implementation

A broad state effort to transform healthcare delivery can take several forms. Some states may effect change through temporary commissions, advisory groups and volunteer efforts.⁷⁹ Others may require more permanent and formal institutional structures, requiring legislation or executive orders.

All oversight authorities in this report were created through legislation but with some differences in governance:

- The **Colorado Commission on Affordable Healthcare** had twelve voting members and five non-voting, ex-officio members, selected by the governor and leadership of the majority and minority parties of the Colorado House and Senate. They also include two consumers on the commission.⁸⁰ Colorado's commission was temporary (2014-2017). The final report was due by statute to the General Assembly by June 30, 2017, and the statute was repealed July 1.
- The **Vermont Green Mountain Care Board** is a five-member independent group who are nominated by a broad-based committee and appointed by the governor.

The board members serve six-year terms and may only be removed for cause. The board also established an advisory committee composed of consumers, patients, businesses and healthcare professionals who provide input to the board.⁸¹

- The **Massachusetts Center for Health Information and Analysis** is an independent agency. CHIA is overseen by a Health Information and Analysis Oversight Council. Representing a wide range of experience and expertise, appointed members serve five-year terms, and are eligible for reappointment. In order to be eligible to serve on the Oversight Council, members must have no official affiliation with acute hospitals, ambulatory surgical centers or surcharge payers.⁸²
- The **Massachusetts Health Policy Commission** is led by HPC staff. There are two executive teams, which have oversight and administrative duties, and four teams that focus on policy, research, and program development. The staff are overseen by an 11-member board of commissioners. The board members are appointed by the governor, attorney general and state auditor depending on their field (consumer advocacy, provider, etc.).⁸³
- The **Maryland Health Services Cost Review Commission** is an independent state agency with seven volunteer Commissioners appointed by the Governor. Each member serves four-year terms. They come from a variety of healthcare backgrounds, representing consumers, providers and hospital administrators, appointed to serve the public interest.⁸⁴ The commission has experienced staff comprising of 33 FTEs (core analytic staff of 10-12).
- The **Pennsylvania Cost Containment Council** has a variety of council members with three main committees: education, healthcare services and data systems. The council is made up of the Secretary of Health, Secretary of Public Welfare, the Insurance Commissioner, six representatives from the business community who are purchasers of healthcare, six

representatives of organized labor, one consumer representative, two hospital representatives, two physician representatives, one representative from Blue Cross Blue Shield of Pennsylvania, one representative of commercial insurance carriers, and one representative of health maintenance organizations.⁸⁵ All members are either appointed by the governor or the speaker of the house and serve for four years.

- The **Oregon Health Authority** is overseen by the nine-member citizen Oregon Health Policy Board and a political appointee. Board members are nominated by the governor and must be confirmed by the Senate. Board members serve four-year terms.⁸⁶
- The **Virginia Joint Commission on Health Care** is comprised of 18 legislative members that can vary based on office terms. Seven members of the Senate are appointed by the Senate Committee on Rules and 10 members from the House of Delegates are appointed by the Speaker of the House. The Secretary of Health and Human Resources serves as a non-voting, ex officio member of the Commission.⁸⁷

Funding Support for Entities

All seven oversight entities were created through legislative statute and receive appropriated funds through the governor's budget. Based on available data, creating an oversight entity is an immense investment which could be a barrier for states with limited funds. As an example, **Vermont's** Green Mountain Care Board was appropriated around \$10 million for 2017.⁸⁸ The funds allotted to the board are a combination of general, special, federal, and grant funds.⁸⁹ **Massachusetts** was appropriated around \$8.5 million dollars for 2017.⁹⁰ Not all states have the resources to take on a large financial responsibility such as creating and investing in an entity with proper infrastructure and salaried employees, and if they do there could be challenges in the continuity of funding and legislative support. States can also create a term-limited entity like **Colorado**, which sought to complete its objectives in three years.

Conclusion

Healthcare spending growth is widely viewed as unsustainable and causing tremendous consumer harm. States play a unique and critical role in transforming healthcare so their residents receive high-quality care for a reasonable cost. It's hard to imagine robust progress on these healthcare value issues without an overarching entity whose role is to look at the “big picture”—taking a comprehensive, systematic approach to understand spending flows, quality issues and progress on disparities—to ensure that all consumers get value for the money they spend.

The good news is that the collected efforts of a few provide enough guidance for states to structure their own oversight authorities focused on reducing healthcare costs, improving quality, bringing spending in line with overall economic growth and implementing new innovations for better value. States such as Vermont, Colorado, Pennsylvania and others have oversight agencies focused on lowering spending, while increasing quality and access for their residents.

At a minimum, oversight authorities must be empowered to focus broadly on healthcare spending and the health outcomes associated with various state programs and to provide actionable recommendations to state legislatures and executive branch agencies based on that research.

To better serve state residents, these entities ideally will also:

- Have robust access to healthcare spending utilization and outcomes data,
- Be able to convene and, if necessary, subpoena stakeholders,
- Have a role in piloting promising innovation, and
- Have a role in monitoring and enforcing global budgets if states adopt that approach.

For success, these entities must be adequately funded, able to operate independently of political whim and undue stakeholder influence. While funding may pose an initial barrier, inspired legislators need only look at

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