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TO: Connecticut Health Care Cabinet
FROM: Megan Burns, Marge Houy and Michael Bailit
DATE: August 22, 2016
Re: Additional detail on state structures for health care policy making

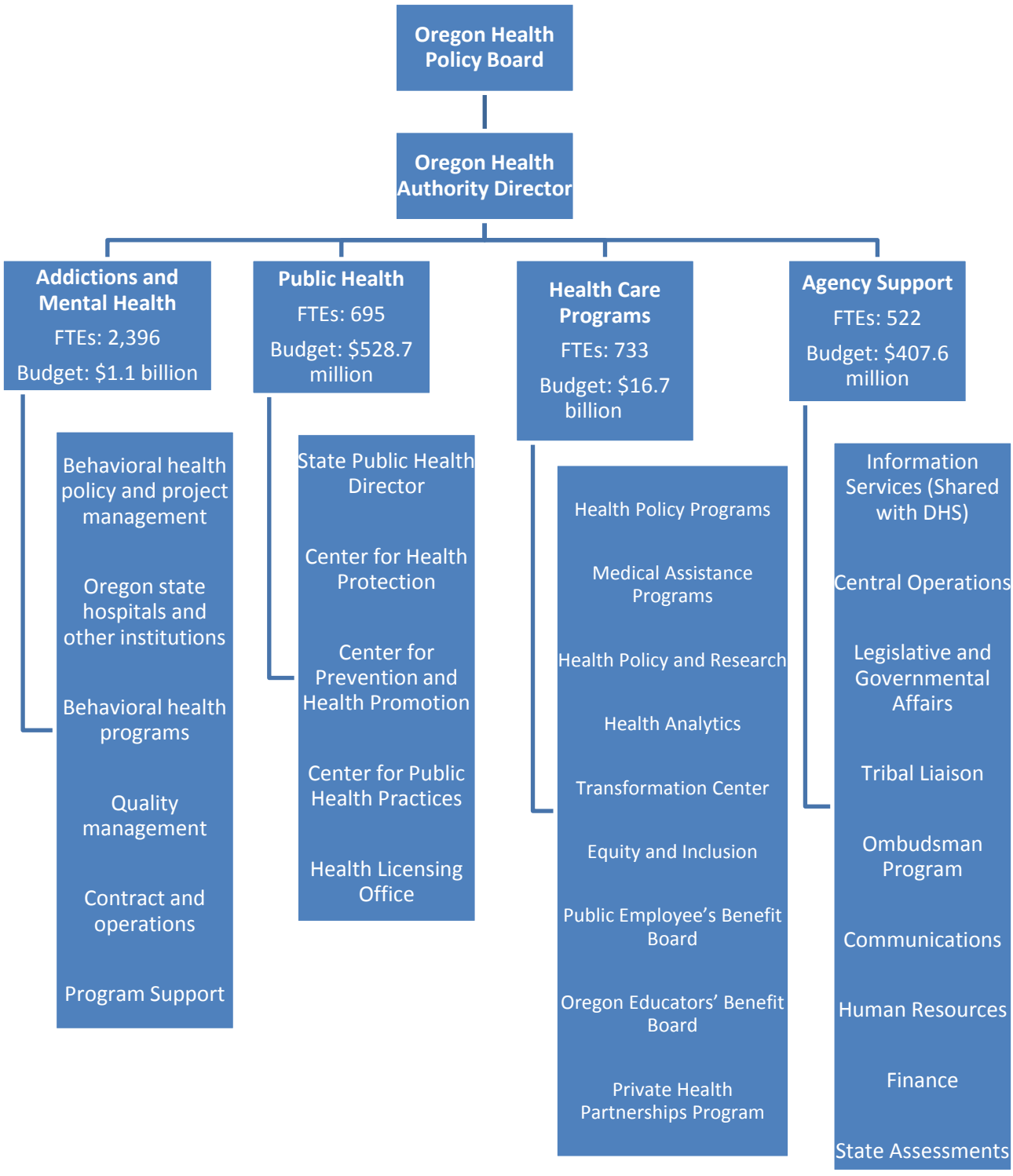
To help inform the Cabinet in its deliberations, especially with respect to the Straw Proposal's strategy on state agency consolidation, we have prepared this memo to provide information on three different approaches to structure state health care policy making activity. This memo describes (1) Oregon and its consolidated health care purchasing and policy making agencies, which is most similar to the structure proposed in the Straw Proposal. (2) Minnesota has utilized executive branch-led councils to varying degrees since 1992 to coordinate health care reform efforts in the state, however, it has not consolidated its agencies. (3) Vermont created an independent board that has been delegated key health care reform policy making functions, including provider and insurer rate regulation and payment and delivery system "innovation." Each state has experienced some success under these models and offers an alternative to our Straw Proposal.

Oregon

Oregon's legislature led the charge to create a centralized agency responsible for health care purchasing and policy making. The Oregon Health Authority (OHA) was created in 2009 by the state's legislative assembly to bring most health-related programs into a single agency to maximize its purchasing power and to contain health care costs.[1] It is accountable to the Oregon Health Policy Board, which consists of nine citizens appointed by the Governor and confirmed by the Senate. In total, the OHA makes up 43% of the state's budget. For the 2015-2017 biennium, the legislature approved $2.12 billion in general funds and $19.47 billion in total funds to support OHA. Medicaid makes up the largest portion of the total OHA budget, and 98% of Medicaid funds are payments for services delivered to beneficiaries. Almost the state's entire contribution of the general fund ($2.12 billion) is used as a match to receive federal funds. Thirty percent of the total OHA budget comes from tobacco taxes, Medicaid provider assessments, grants, alcohol taxes, fees, estate collections, self-insurance payments, health care premiums, plan assessments, third party recoveries, pharmaceutical rebates, charges for services and intergovernmental transfers.

Below is an organizational chart of the state structure provided from the Oregon Health Authority's 2015-2017 budget overview, including budget and FTEs.

[1] Oregon Legislative Fiscal Office. "2015-2017 Legislatively Adopted Budget." October, 2015


Oregon Health Policy Board
Oregon Health Authority Director
Addictions and Mental Health
FTEs: 2,396
Budget: $1.1 billion
Behavioral health policy and project management
Oregon state hospitals and other institutions
Behavioral health programs
Quality management
Contract and operations
Program Support
Public Health
FTEs: 695
Budget: $528.7 million
State Public Health Director
Center for Health Protection
Center for Prevention and Health Promotion
Center for Public Health Practices
Health Licensing Office
Health Care Programs
FTEs: 733
Budget: $16.7 billion
Health Policy Programs
Medical Assistance Programs
Health Policy and Research
Health Analytics
Transformation Center
Equity and Inclusion
Public Employee's Benefit Board
Oregon Educators' Benefit Board
Private Health Partnerships Program
Agency Support
FTEs: 522
Budget: $407.6 million
Information Services (Shared with DHS)
Central Operations
Legislative and Governmental Affairs
Tribal Liaison
Ombudsman Program
Communications
Human Resources
Finance
State Assessments

Minnesota

Minnesota has planned and led waves of health care reform activity through a series of interagency executive councils. Some of these bodies have included external stakeholders, while others have been internal to the executive branch. The original council was created in 1992 under Governor Arne Carlson and continued at least through 2013, with different names and somewhat different focuses, under four different governors.[2] The repeated use of these non-statutorily-defined bodies reflects the collaborative culture of the state.

In 1992, Governor Carlson established the Health Care Commission which had the responsibility to develop a cost containment plan that would slow the growth of health care spending by at least 10 percent a year over 5 years. It had 25 members on the board consisting of:

- 4 members representing health plan companies;
- 6 members representing health care providers (1 member each appointed by MHA, MMA, and MNA; 1 rural physician appointed by the governor; 2 members appointed by the governor, not otherwise represented);
- 4 members representing employers;
- 5 members representing consumers;
- 3 members representing labor unions; and
- commissioners of commerce, employee relations, and human services.

Governor Jesse Venture created the Health Policy Council which was co-chaired by the Minnesota Health Department and Human Services Department (the Medicaid agency).

Governor Pawlenty appointed former US Senator Durenberger to chair the Citizens Forum on Health Care Costs for improving quality and reducing costs. In response to the Citizens Forum's recommendations, the Governor created a Health Care Cabinet in 2004 that was made up of six state agency commissioners and charged with implementation of the Citizens Forum recommendations. The Cabinet was led by the Commissioner of the Department of Employee Relations and its charge was to "use the buying power of the state, [and] partner with the private sector to make substantive changes to Minnesota health care purchasing." Its chief success was the creation of the "Smart Buy" Alliance, a public-private partnership to improve the health care quality and costs in the state.

Current Governor Dayton created the Subcabinet for Health Reform that included state commissioners for Health, Human Services, and Commerce who worked together to implement the Affordable Care Act.

[2] Bailit M and Burns M. "All Together Now: Coordinating California's Public Sector Health Care Purchasing." California HealthCare Foundation, September 2013.

Vermont

In 2011, state legislation authorized formation of the Green Mountain Care Board (GMCB), an independent board with broad authority for regulation, innovation, and evaluation of the state's health care system. The five paid members of the board are nominated by a committee and appointed by the Governor. The 2011 legislation transferred to the GMCB responsibility for approving hospital budgets and major health care capital investments, as well as small-group and individual health insurance rates. The legislation gave the GMCB the authority to regulate provider rates, an authority the board has yet to utilize.

The legislation also tasked the GMCB with oversight of multi-payer payment reform pilot projects. These have included a three-year multi-payer, public/private ACO pilot and the development of an all-payer CMS waiver proposal that includes the establishment of a global health care budget. The GMCB also has the responsibility to approve the state's health care workforce plan, its health information technology plan and minimum benefit exchange requirements.

The GMCB employs 27 FTEs (5 of whom are the board members) and has a $9 million dollar budget in 2016.

Vermont has not consolidated the agencies that are responsible for delivering and / or paying for the health care services.

Conclusion

Coordinating health care purchasing and policy has long been a challenge for states, and few have done it well. Oregon, Minnesota and Vermont are examples of three states that *have* achieved some success. It is not a coincidence that all three states have a culture that is generally more collaborative than that of Connecticut. The three states have taken different approaches to coordinating health purchasing and policy making. Each of these examples could be used as the basis for an alternative to the Straw Proposal.