RUPRI Center for Rural Health Policy Analysis

A Review of State Health Care Commission Models

The mission of the RUPRI Center is to provide timely analysis to federal and state health policy makers, based on the best available research. The research of the RUPRI Center focuses on rural health care financing/system reform, rural systems building, and meeting the health care needs of special rural populations. Specific objectives include conducting original research and independent policy analysis that provides policy makers and others with a more complete understanding of the implications of health policy initiatives, and disseminating policy analysis that assures policy makers will consider the needs of rural health care delivery systems in the design and implementation of health policy.

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INTRODUCTION

Under contract with the Wyoming Health Care Commission (WHCC), the RUPRI Center for Rural Health Policy Analysis (RUPRI) developed this document to identify established models of state health care commissions throughout the nation to better inform the design and implementation of recommendations from the June 2007 RUPRI report to the WHCC.

Information about 50 state health care commissions was collected. Search sources included commission websites, state rules, regulations and statutes, and annual reports. Several search terms were used to collect commission information. Search terms included: "state health care commission," "state health care council," "state health care board, "state health care office," "state health care task force, "independent state health care commission," "independent state health care council," "independent state health care board, "independent health care office," "independent state health care task force," and "state health care agency." Data were organized into categories of structure, process and function. Of the original 50 commissions, nine were selected for further evaluation because they monitor, assess and evaluate state health care delivery systems. The selected cases include:

- California Health Policy and Data Advisory Commission (CHPDAC)
- Connecticut Office of Health Care Access (COHCA)
- Delaware Health Care Commission (DHCC)
- Georgia Health Strategies Council (GHSC)
- Maryland Health Care Commission (MHCC)
- New Mexico Health Policy Commission (NMHPC)
- North Carolina Medical Care Commission (NCMCC)
- North Dakota State Health Council (NDSHC)
- Oregon Health Policy Commission (OHPC)

Analysis of selected cases focused on four components: purpose, composition, authority, and history of accomplishments. Specific criteria for each component were established to facilitate the review process.

- Purpose: To identify the purpose for each case, analysis focused on the ability to influence state health policy with long-term implications, including, in some cases, the power to implement enacted policies.

- Composition: The composition of the commission in each case was examined to determine how many members serve, and how they are appointed, and how they relate to other state entities.

- Authority: The authority of each commission was analyzed to establish the circumstances for its creation (i.e. legislative mandate, executive order, etc.), its specific powers and the structure of accountability—both internal and external.

- Accomplishments: We also report how accomplishments are identified to establish examples of how each commission monitors, assesses and evaluates state health care delivery systems.

CASE STUDY FINDINGS

The following case study findings are presented as general findings, selected best fit models, and commission summary tables. The general findings are organized by examples of models for each element overall. The selected best fit models highlight and discuss those commissions that demonstrate elements that are both desirable and feasible for the development of a new health care commission in Wyoming. The summary tables for all nine selected commissions are organized to parallel the four elements.

General Findings

Purpose:

- The basic purpose of each commission is to provide guidance and recommendations for the development and implementation of health policy to state executive and legislative branches and/or a governing agency or department.

- The North Carolina Medical Care Commission has a unique purpose in its role administering the Finance Act, which provides financing for construction and equipment projects for health care facilities.

Composition:

- The Connecticut Office of Health Care Access is administered by a single commissioner; all other commissions have multiple commissioners inclusive of multiple sectors, agencies, and organizations.

- In most commissions, the composition of each commission is organized around committees, work groups/units, divisions, and/or centers.

Authority:

- Four entities—the Delaware Health Care Commission, the Maryland Health Care Commission, the New Mexico Health Policy Commission, and the Oregon Health Policy Commission, have the independent authority to develop and implement health policy.

- The Georgia Health Strategies Council plays a significant role in developing, implementing, and monitoring the Georgia State Health Plan.

Accomplishments:

- Most commissions demonstrate their abilities to monitor, assess, and evaluate state health care delivery systems through the publication and dissemination of state policy briefs and reports designed to study specific health policy issues for their respective state.

Selected Best Fit Models

Five commissions were selected as best fits for integrating a broad spectrum of representatives and stakeholders, as well as encompassing a design of expectations that act both broadly and specifically. These five commissions demonstrate how important it is to have a widely representative commission if consensus between government, public, and private stakeholders is to be reached. While the longevity of each commission varies, those selected represent examples of established entities that demonstrate elements that are necessary to consider for the development of a new health care commission in Wyoming:

- California Health Policy and Data Advisory Commission (CHPDAC): This commission could be a model for establishing the importance of information technology and data collection design and reporting. The CHPDAC was established in 1985, as an entity within the California state government. Composed of 13 commissioners, representing stakeholders from across the health care system, business, labor, insurance, prepaid health, as well as the public, the CHPDAC plays an integral role in the development of health policy, planning, and information issues in California. The commission was created as a result of transfer of authority over health facilities data collection and disclosure systems from the California Health Facilities Commission. Its role is to establish efficient and effective data reporting mechanisms for accurate and timely public disclosure of information regarding California's hospitals, long-term care facilities, licensed clinics, and home health agencies.

- Delaware Health Care Commission (DHCC): This commission focuses on health care access, quality and cost. The DHCC was created in 1990 to review and make policy recommendations that promote a comprehensive health care system that ensures quality, and is both efficient and effective. The 11 members that make up the commission represent both executive and legislative branches of state government in addition to a mixture of members from both private and public sectors. The DHCC promotes a comprehensive health care system by administering initiatives addressing challenges related to the uninsured action plan, information and technology, health care workforce and development, research and policy development, and other specific health care issues. Beginning in 1995, the DHCC began using a committee system to further facilitate the process of consensus building through the Delaware Health Information Network, the Delaware Institute of Medical Education and Research, and the Delaware Institute for Dental Education and Research.

- Georgia Health Strategies Council (GHSC): This council functions to develop Georgia's state health plan. The GHSC was created in 2004 as an advisory body to provide policy direction and health planning guidance to the Division of Health Planning, the Office of General Counsel, and the Department of Community Health. The 26 members of the GHSC represent a wide spectrum of stakeholders of both health care and consumer interests. It serves serving as both a facilitator and a forum for public debate and policy making that directly influence the structure of Georgia's health care delivery system and other health care issues. Organized around six advisory committees of advocates and technical experts, members of the GHSC are informed on a range of health care delivery system issues that

facilitate the evaluation of Georgia's existing health care resources for accessibility (e.g. geographical, financial, cultural, administrative), quality, comprehensiveness, and cost.

- New Mexico Health Policy Commission (NMHPC): This commission is an independent entity participating in health planning. The NMHPC was created in 1991 to monitor the implementation of state health policy through research, guidance, and recommendations to influence health care planning in New Mexico. The 9 members of the commission reflect the ethnic, economic, geographic, and professional diversity of the state. It is charged with three overarching functions: to implement macro-level systems analysis to better inform the policy making process; to administer health information systems and data collection to facilitate the state health plan, support health resource planning, and provide consumer information; and to participate in the cross-sector Health Information Alliance to develop a statewide health information network to decrease duplication of data collection and reporting.

  Legislative update: In October 2007 Governor Bill Richardson announced his plan for universal health care coverage for the state of New Mexico. Under the proposal, the New Mexico Health Care Coverage Authority (NMHCCA) would be created to administer most of the mandates in the proposal, including the decisions on benefits and eligibility. If passed, the NMHCCA would take over the New Mexico Health Policy Commission and its budget beginning in July 2008. Provisions in HB 147 would increase the number of members currently serving on the NMHPC from 9 to 11. In addition, the NMHCCA would be required to establish a minimum of 6 expert advisory councils to provide members with information regarding policy and program recommendations to increase efficiency and effectiveness. The advisory councils include: a finance council, a federal impact council, a Native American health council, a health disparities council, a delivery system council, and a council of state-funded or state-created health care or health coverage agencies[1].

- Oregon Health Policy Commission (OHPC): This commission advises the legislative ane executive branches of state government. The OHPC was established in 2003 to identify and analyze health care issues affecting Oregon, and to make policy recommendations to the Governor, the Oregon State Legislature, and the State Office for Oregon Health Policy and Research for health care system delivery planning and development efforts. Composed of 10 members, the OHPC is organized around workgroups that focus on a specific topic, issue, or policy, and may change from year to year as needed. Acting as a policy making body and statewide data clearing house, the OHPC serves as a forum discussion of health policy and health care issues.

STATE SUMMARIES FOLLOW

[1] Kaiser Daily Health Policy Report, Kaiser Family Foundation. Retrieved on 2/29/08 from http://www.kaiser network.org/daily_reports/rep_ hpolicy_recent_rep.cfm?dr_cat=3&show=yes&dr_DateTime=10-30-07#48530 and http://www.kaisernetwork.org/daily_reports/rep_hpolicy_recent_rep.cfm?dr_cat=3&show=yes&dr_DateTime=02-07-08#50292

California Health Policy and Data Advisory Commission (CHPDAC)[i]

Purpose	Composition	Authority	History of Accomplishments
• Advise the California Office of Statewide Health Planning and Development and the California Human Services Agency on health policy, planning, and information issues. • Advise the Director of OSHPD on policies and procedures for the collection and disclosure of information about California hospitals, long-term care facilities, licensed clinics, and home health agencies.	• 13 members: each represent a specific major stakeholder in health care delivery, including physicians, hospitals, long-term care facilities, ambulatory surgery centers, business, labor, insurance, prepaid health, and the general public. • Nine commissioners are appointed by the Governor, and two each are appointed by the Speaker of the Assembly and the Senate Rules Committee. <u>Organizational Structure</u> The CHPDAC currently presides over 3 committees: 1. *AB 524 Technical Advisory Committee* 2. *Appeals Committee* 3. *Health Data and Public Information Committee*	• Created in 1985 under the Health Data and Advisory Council Consolidation Act (Health and Safety Code, Division 107, Part 5, Chapter 1, Section 128675 et seq.). • Advisory body <u>Scope of Authority</u> • Advise OSHPD on: (1) the implementation of new, consolidated data system, (2) the collection and reporting of health facility and other provider data (3) changes to the uniform accounting and reporting systems for health facilities, (4) adoption, amendment, or repeal of regulations it proposes prior to their submittal to the Office of Administrative Law (5) the format of individual health facility or other provider data reports and on any technical and procedural issues, and (6) the formulation of general policies • Submit annual report regarding changes to existing data collection systems and forms • Advise the Secretary of Health and Welfare on the formulation of general policies • Recommend, in consultation with the technical advisory committee elements necessary for the production of outcome reports • Conduct public meetings	• The CHPDAC held hearings; created committees to advise on the health information needs for purchasers and payers, policymakers, providers, and consumers; and reviewed activities that supported the creation and birth of the MIRCal online data collection system. • The CHPDAC hopes to expand the MIRCal system to include data from emergency departments and ambulatory surgery from hospitals and freestanding ambulatory surgery centers, after the regulations are adopted.

Connecticut Office of Health Care Access (COHCA)[ii]

Purpose	Composition	Authority	History of Accomplishments
• Ensure that the citizens of Connecticut have access to a quality health care delivery system by advising policy makers of health care issues; informing the public and the industry of statewide and national trends; and designing and directing health care system development.	• 1 Commissioner; appointed by the governor <u>Organizational Structure</u> The COHCA consists of the following three programs: (1) Office of the Commissioner (2) Certificate of Need & Compliance (3) Research & Planning	• Created in 1994 under Chapter 368z, Connecticut General Statutes. • Advisory body <u>Scope of Authority</u> • Administers the Certificate of Need and companion programs • Responsible for collecting patient-level outpatient data from health care facilities or institutions • Responsible for establishing a cooperative data collection effort, across public and private sectors • Oversee and coordinate health system planning for the state • Monitor health care costs • Implement and oversee health care reform as enacted by the General Assembly	• In 2006, OHCA processed over 150 Certificate of Need applications from hospitals, surgical facilities, providers and other healthcare facilities. • Through grant-funded data collection, research and analysis activities, OHCA data collection and analysis provided background for health reform discussions in the executive and legislative branches during 2006. OHCA worked within the political and economic environment to support the development of cost-effective policy options to increase health care coverage in the state, especially for low-income, working uninsured families. • OHCA released numerous publications and reports in 2006 on a variety of topics including hospital financial stability, uninsured hospitalizations, pediatric psychiatric beds, and uninsured survey results. • In 2006, OHCA leadership and staff presented research findings to the Medicaid Managed Care Council, and participated on a significant number of committees including the Child Poverty and Prevention Council, Health Care Cost Containment Committee, Committee to Examine Hospital Inpatient Behavioral Health Bed Capacity for Children, Behavioral Health Partnership, and Connecticut Interdisciplinary Health Policy Team.

Delaware Health Care Commission (DHCC)[iii]

Purpose	Composition	Authority	History of Accomplishments
• Review and make policy recommendations to promote 100% access to health care services • Promote a comprehensive health care system assuring quality care • Promotes a regulatory and financial framework to manage the affordability of health care	• 11 members: 4 government officials - the Secretary of Finance, Secretary of Health & Social Services, Secretary of Children, Youth & Their Families and the Insurance Commissioner - are joined by 6 private citizens appointed either by the Governor, the Speaker of the House or the President Pro Tempore of the Senate. • The composition is a balance between the executive and legislative branches of government and the public and private sectors. <u>Organizational Structure</u> The DHCC oversees 5 major initiatives: (1) Uninsured Action Plan (2) Information & Technology (3) Health Professional Workforce Development (4) Research & Policy Development (5) Specific Health Care Issues & Affiliated Groups	• Created in 1990 by the Delaware General Assembly • Independent policy setting body <u>Scope of Authority</u> • Hire staff, contract for consulting services, conduct any technical and/or actuarial studies which it deems to be necessary to support its work, and to publish reports • Conduct pilot projects to test methods for catalyzing private-sector activities that will help the state meet its health care needs • Administration of the Delaware Institute of Medical Education and Research (DIMER) and the Delaware Institute for Dental Education and Research (DIDER)—both serve as advisory boards to the Commission • Recommend methods to reduce and control health care costs in conjunction with the private sector	• In 1996, assumed administrative responsibility for the Delaware Institute of Medical Education and Research to provide opportunities in medical education for state students and to meet state needs for health care professionals • In 1997, the Commission assumed responsibility for the creation and maintenance of the Delaware Health Information Network Delaware Health Education Pipeline Study and Report - April 2007: • This study of health education and training programs is intended to provide baseline information that will be useful to policymakers and education leaders in the state.

Georgia Health Strategies Council (GHSC)[iv]

Purpose	Composition	Authority	History of Accomplishments
• Develop Georgia's State Health Plan • Address policy issues concerning access to health care services • To provide policy direction and health planning guidance for the Division of Health Planning and the Department of Community Health	• 26 members: appointed by the Governor and represent a wide range of health care and consumer interests <u>Organizational Structure</u> The GHSC regularly convenes committees of advocates and technical experts to advise members on health plan changes and improvements. Currently there are six advisory committees: • Indigent and Charity Care Ad Hoc Committee • Ambulatory Surgery Services Technical Advisory Committee • Inpatient Physical Rehabilitation Services Technical Advisory Committee • Psychiatric & Substance Abuse Services Technical Advisory Committee • Positron Emission Tomography Services Technical Advisory Committee • Stereotactic Radiosurgery Technical Advisory Committee	• Created in December 2004, under O.C.G.A. 31-6-21 • Advisory body <u>Scope of Authority</u> • Adopt the state health plan and submit it to the Board of Community Health for Approval • Review, comment on, and make recommendations to the department on the proposed rules for the administration of the law • Conduct ongoing evaluation of Georgia's existing health care resources for accessibility, including financial, geographic, cultural, and administrative accessibility, quality, comprehensiveness and cost • Study long-term comprehensive approaches to providing health insurance to the entire population	• During FY 2006, The Technical Advisory Committees (TACs) for Psychiatric and Substance Abuse and Inpatient Rehabilitation met and revised rules for Psychiatric and Substance Abuse services, Comprehensive Inpatient Physical Rehabilitation services, Traumatic Brain Injury facilities, and new rules for Long Term Care Hospitals for which the GHSC approved rules submitted by each TAC.

Maryland Health Care Commission (MHCC) [v]

Purpose	Composition	Authority	History of Accomplishments
• Develop and carry out new health policies including planning for health system needs • Promote informed decision-making, increased accountability, and improved access • Provide timely and accurate information on availability, cost, and quality of services to policy makers, purchasers, providers and the public via data gathering, public reporting, planning and regulation.	• 13 Members: appointed by the Governor, with the advice and consent of the Senate, for a term of four years. <u>Organizational Structure</u> The commission is organized around the health care systems that are targeted for evaluation, regulation, or influence through a wide range of tools (data gathering, public reporting, planning and regulation) to improve quality, address costs, or increase access. To achieve this end, the MHCC oversees 5 centers: • Center for Hospital Services • Center for Long-term and Community-based Care • Center for Healthcare Financing and Health Policy • Center for Information Services and Analysis • Center for Health Information Technology • The MHCC is administered by an Executive Director and 3 Deputy Directors	• Created in 1999 by merging the Health Care Access and Cost Commission and the Maryland Health Resources Planning Commission under the Annotated Code of Maryland, Health General Article § 19-101, et seq. • Independent state regulatory agency <u>Scope of Authority</u> • Develop health care cost containment strategies and promote the development of a health regulatory system • Facilitate the public disclosure of medical claims data for the development of public policy • Establish and develop a medical care data base on health care services rendered by health care practitioners • Develop a uniform set of effective benefits to be included in the Comprehensive Standard Health Benefit Plan • Establish standards for the operation and licensing of medical care electronic claims clearinghouses in Maryland • Reduce the costs of claims submission and the administration of claims for health care practitioners and payers • Determine the cost of mandated health insurance services in the State • Administer the Maryland Trauma Physician Services Fund	<u>Policy Changes and Reforms in 2006</u> • Reforms in the small group market—completion of 6 month reform process culminating in a new Comprehensive Standard Health Benefit Plan • The Certificate of Need Task Force considered ways to streamline the CON process via a series of changes in statute, regulation, and day to day practice, of which most are already underway • Promoted Electronic Health Records and Secure Health Information Exchange by: (1) staffing the Task Force on the Electronic Health Record, (2) conducting a study to identify barriers to appropriate information exchange in Maryland and to develop strategies to address privacy and security, and (3) collaborating with the Health Services Cost Review Commission through a competitive process, to fund several $250,000 projects to plan and then a $10 million project to implement the first phase of a state-wide health information exchange. • Provided consumers with better information to make better choices through quality reporting using objective measures, patient and family satisfaction measures, and the Price Transparency Project that will soon publish prices for common physician services (both billed amounts and allowed amounts) by county, specialty, and specific service, giving the 25th, 50th, and 75th percentiles • Reports that help guide policy include an annual report on health care expenditures in Maryland, an analysis of the problem of the uninsured in Maryland, a summary of insurance coverage in the state, and special studies of importance to policymakers, including prescription drug spending, uncompensated care, and primary care services.

New Mexico Health Policy Commission (NMHPC)[vi]

Purpose	Composition	Authority	History of Accomplishments
• Develop a plan and monitor the implementation of state health policy • Provide a forum for the discussion of complex and controversial health policy and planning issues including the interrelations with education, the environment and economic well-being.	• 9 members: Administratively attached to the Department of Finance and Administration, members are appointed by the governor with the advice and consent of the senate to reflect the ethnic, economic, geographic and professional diversity of the state <u>Organizational Structure</u> • The NMHPC staff is organized under 4 work units: (1) Information technology (2) Program (3) Administration (4) Economic research.	• Created in 1991 • Independent state agency <u>Scope of Authority</u> • Obtain and evaluate factors that affect the availability and accessibility of health services and health care personnel in the public and private sectors • Perform needs assessments and make recommendations regarding the training, recruitment, placement and retention of health professionals in underserved areas of the state • Establish a process to prioritize recommendations on program development, resource allocation and proposed legislation • Prepare and publish an annual report describing the progress in addressing the state's health policy and planning issues • Distribute the annual report to the governor, appropriate state agencies and interim legislative committees and interested parties • Provide information and analysis on health issues to facilitate the synthesis of health policy in the public and private sectors and respond to requests by the executive and legislative branches of government.	• The NMHPC is responsible for the publication of *Quick Facts*, the annual *County Financing of Health Care*, the annual *New Mexico Consumer Guide to Managed Care*, *Hospital Inpatient Discharge Data Reports*, and *Geographic Access Data System Report*. • The NMHPC participated in task force and workgroups including the Cultural Competence Education in the Health Sciences Task Force, the Regional Health Information Organization Steering Committee, the Telehealth Commission and Alliance, the Interagency Behavioral Health Purchasing Collaborative and Behavioral Health Planning Council, and the Women's Health Advisory Council. • Participated in the third annual Physician Workforce Research Conference sponsored by the Association of American Medical Colleges, the Annual Health Provider Retreat sponsored by New Mexico Health Resources. • Participated in Governor Richardson's Higher Education Summit sponsored by the New Mexico Higher Education Department.

North Carolina Medical Care Commission (NCMCC)[vii]

Purpose	Composition	Authority	History of Accomplishments
• To adopt, recommend or rescind rules for regulation of most health care facilities • To administer the Health Care Facilities Act—enabling the NCMCC to issue tax-exempt revenue bonds	17 members: • 7 members are nominated (subject to governor approval) and 10 are appointed by the governor for 4-year terms • 3 members are nominated by the North Carolina Medical Society • 1 member is nominated by the North Carolina Pharmaceutical Association • 1 member is nominated by the North Carolina State Nurses' Association • 1 member is nominated by the North Carolina Hospital Association • 1 member is nominated by the Duke Endowment. <u>Organizational Structure</u> • NCMCC is attached organizationally to the Department of Health and Human Services, Division of Facility Services, and is staffed by that Agency.	• Created in 1946 under the Hospital Survey and Construction Act (Hill-Burton) • Regulatory body <u>Scope of Authority</u> • Has the duty and power to promulgate, adopt, amend and rescind rules regarding the regulation and licensing or certification of health care facilities • Issue tax-exempt revenue bonds to finance construction and equipment projects for non-profit and public hospitals • Survey hospital resources of the State and formulate a statewide program for construction and maintenance of local hospitals, health centers and related facilities, and receive and administer federal and state funds appropriated for such purposes • Make loans to medical students • Survey all factors concerning the location of the expanded university medical school. from a two-year to a four-year program)	<u>Health Care Facilities Finance Act</u> • Passed by the General Assembly in 1975 in order to provide an alternative means of financing health care facility construction and modernization. • The Act authorizes the NCMCC to review applications by a public or nonprofit agency, and to issue tax-exempt revenue bonds and notes, and lend the proceeds to the applicant. • Bonds are sold through the North Carolina Local Government Commission (the “LGC”) and are retired from loan payments made by the applicant.

North Dakota State Health Council (NDSHC)[viii]

Purpose	Composition	Authority	History of Accomplishments
• The NDSHC serves as the North Dakota Department of Health's advisory body	• 11 members: appointed by the governor for 3-year terms; 4 members are appointed from the health-care provider community, 5 from the public sector, 1 from the energy industry, and 1 from the manufacturing and processing industry • NDSHC officers must be elected annually <u>Organizational Structure</u> • Any state agency may serve in an advisory capacity to the NDSHC	• Created under - NDCC § 23-01-02 as part of the North Dakota Department of health • Advisory body <u>Scope of Authority</u> • Monitor overall health care costs and quality of health care in the state • Recommend to the appropriate interim legislative committees changes to the health care system in the state • Establish standards, rules, and regulations which are found necessary for the maintenance of public health, including sanitation and disease control • Provide for the development, establishment, and enforcement of basic standards for hospitals and related medical institutions which render medical and nursing care (including construction and maintenance of such institutions) • Hold hearings on all matters brought before it by applicants and licensees of medical hospitals with reference to the denial, suspension, or revocation of licenses • Approve applications for alternative health care services pilot projects • Publish an annual report on health care in the state • Make rules and regulations for the government of the council and its officers and meetings, including the time and place of meetings of the council	• N/A

Oregon Health Policy Commission (OHPC)[ix]

Purpose	Composition	Authority	History of Accomplishments
• Develop a plan for and monitor the implementation of state health policy • Identify and analyze significant health care issues affecting the state. • Partner with health care experts and stakeholders around the state to develop projects which ensure access to essential health care and support services, increase health care quality and improve health outcomes for individuals and society, control costs, and encourage healthy lifestyles.	• 14 members: Administered through the Office for Oregon Health Policy & Research, there are 10 voting members appointed by the Governor and 4 legislators serving as non-voting advisory members • Members represent all of the state's congressional districts and bring a rich variety of health policy and health care experience <u>Organizational Structure</u> The OHPC has established workgroups to assist with its mandated duties. Each work group focuses on a specific topic, for 2005-6:: • Quality & Transparency • Delivery System Models • Quality & Transparency • Childhood Obesity Study - Research/Science Workgroup • Childhood Obesity Study - Practitioner/Policy Workgroup • Electronic Health Records & Data Connectivity • Healthy Oregon .	• Created in 2003 under HB 3653 • State policy making and advisory body <u>Scope of Authority</u> • Act as a policy-making body for a statewide data clearinghouse • Review Office for Oregon Health Policy and Research (OHPR) reports • Provide a forum for discussion of health policy and health care issues • Identify and analyze significant health policy and health care issues affecting the state and make recommendations to the Governor • Prepare and submit to the Governor and Legislative Assembly resolutions relating to health policy and health care reform • Review proposed policy modifications to the state's Medicaid program • Act as primary advisory committee to OHPR, the Governor and the Legislature	• *Road Map for Health Care Reform: Creating a High-Value, Affordable Health Care System* and *Covering the Uninsured: The Cost to Oregon* (companion document) (2007): The Governor directed the OHPC to develop recommendations for establishing an affordable and sustainable health care system that is accessible to all Oregonians. • *March 2005 Oregon Health Policy Commission Report* (2005): The OHPC Subcommittee on Electronic Health Records (EHR) and Data Connectivity was formed to develop recommendations for 1) fostering the adoption of EHR and 2) developing the infrastructure for the secure exchange of electronic health data in Oregon.

APPENDIX A: DETAILED CASE STUDY FINDINGS

California Health Policy and Data Advisory Commission (CHPDAC)

Purpose

The purpose of the CHPDAC is to advise the California Office of Statewide Health Planning and Development (OSHPD) and the California Health and Human Services Agency on health policy, planning, and information issues. Additionally, the CHPDAC advises the Director of OSHPD regarding policies and procedures guiding the collection and public disclosure of information about California's hospitals, long-term care facilities, licensed clinics, and home health agencies.

Composition

The 13 commissioners each represent a specific major stakeholder in health care delivery, including physicians, hospitals, long-term care facilities, ambulatory surgery centers, business, labor, insurance, prepaid health, and the general public. Nine commissioners are appointed by the Governor, and two each are appointed by the Speaker of the Assembly and the Senate Rules Committee.

The Commission currently has three committees, which meet as necessary to fulfill their assignments.

- *AB 524 Technical Advisory Committee*: Advises the Office on risk-adjusted outcomes studies of care in California hospitals. These studies assist in the review and improvement of the quality of care provided in hospitals. Studies include maternal outcomes, acute myocardial infarction, disk surgery, and hip fractures, and community-acquired pneumonia with new a study beginning on care in intensive care units (ICU's) of hospitals.
- *Appeals Committee*: Hears appeals by health facilities fined for late data reporting to the Office of Statewide Health Planning and Development. The committee forwards its recommendation to the Director of OSHPD for consideration.
- *Health Data and Public Information Committee*: Reviews data collection issues relating to hospitals, long-term care facilities, clinics, home health agencies, and ambulatory surgery centers.

Authority

The CHPDAC was created in 1985 under the Health Data and Advisory Council Consolidation Act (Health and Safety Code, Division 107, Part 5, Chapter 1, Section 128675 et seq.).

Scope of Authority

- Advise the office on the implementation of the new, consolidated data system.
- Advise the office regarding the ongoing need to collect and report health facility data and other provider data.

- Annually develop a report to the director of the office regarding changes that should be made to existing data collection systems and forms. Copies of the report shall be provided to the Senate Health and Human Services Committee and to the Assembly Health Committee.
- Advise the office regarding changes to the uniform accounting and reporting systems for health facilities.
- Conduct public meetings for the purposes of obtaining input from health facilities, other providers, data users, and the general public regarding this chapter and Chapter 1 (commencing with Section 127125) of Part 2 of Division 107.
- Advise the Secretary of Health and Welfare on the formulation of general policies which shall advance the purposes of this part.
- Advise the office on the adoption, amendment, or repeal of regulations it proposes prior to their submittal to the Office of Administrative Law.
- Advise the office on the format of individual health facility or other provider data reports and on any technical and procedural issues necessary to implement this part.
- Advise the office on the formulation of general policies which shall advance the purposes of Chapter 1 (commencing with Section 127125) of Part 2 of Division 107.
- Recommend, in consultation with a 12-member technical advisory committee appointed by the chairperson of the commission, to the office the data elements necessary for the production of outcome reports required by Section 128745.

    - The technical advisory committee appointed pursuant to subdivision shall be composed of two members who shall be hospital representatives appointed from a list of at least six persons nominated by the California Association of Hospitals and Health Systems, two members who shall be physicians and surgeons appointed from a list of at least six persons nominated by the California Medical Association, two members who shall be registered nurses appointed from a list of at least six persons nominated by the California Nurses Association, one medical record practitioner who shall be appointed from a list of at least six persons nominated by the California Health Information Association, one member who shall be a representative of a hospital authorized to report as a group pursuant to subdivision of Section 128760, two members who shall be representative of California research organizations experienced in effectiveness review of medical procedures or surgical procedures, or both procedures, one member representing the Health Access Foundation, and one member representing the Consumers Union. Members of the technical advisory committee shall serve without compensation, but shall be reimbursed for any actual and necessary expenses incurred in connection with their duties as members of the technical advisory committee.
    - The commission shall submit its recommendation to the office regarding the first of the reports required pursuant to subdivision

        - of Section 128745 no later than January 1, 1993. The technical advisory committee shall submit its initial recommendations to the commission pursuant to subdivision (d) of Section 128750 no later than January 1, 1994. The commission, with the advice of the technical advisory

committee, may periodically make additional recommendations under Sections 128745 and 128750 to the office, as appropriate.

- Assess the value and usefulness of the reports required by Sections 127285, 128735, and 128740. On or before December 1, 1997, the commission shall submit recommendations to the office to accomplish all of the following:

  - Eliminate redundant reporting.
  - Eliminate collection of unnecessary data
  - Augment data bases as deemed valuable to enhance the quality and usefulness of data.
  - Standardize data elements and definitions with other health data collection programs at both the state and national levels.
  - Enable linkage with, and utilization of, existing data sets.
  - Improve the methodology and data bases used for quality assessment analyses, including, but not limited to, risk-adjusted outcome reports.
  - Improve the timeliness of reporting and public disclosure.

- The commission shall establish a committee to implement the evaluation process. The committee shall include representatives from the health care industry, providers, consumers, payers, purchasers, and government entities, including the Department of Managed Health Care, the departments that comprise the Health and Welfare Agency, and others deemed by the commission to be appropriate to the evaluation of the data bases. The committee may establish subcommittees including technical experts.
- In order to ensure the timely implementation of the provisions of the legislation enacted in the 1997-98 Regular Session that amended this part, the office shall present an implementation work plan to the commission. The work plan shall clearly define goals and significant steps within specified timeframes that must be completed in order to accomplish the purposes of that legislation. The office shall make periodic progress reports based on the work plan to the commission. The commission may advise the Secretary of Health and any significant delays in following the work plan. If the Welfare of commission determines that the office is not making significant toward achieving the goals outlined in the work plan, the commission shall notify the office and the secretary of that determination. The commission may request that the office submit a plan of correction outlining specific remedial actions and

timeframes for compliance. Within 90 days of notification, the office shall submit a plan of correction to the commission.

- As the office and the commission deem necessary, the commission may establish committees and appoint persons who are not members of the commission to these committees as are necessary to carry out the purposes of the commission. Representatives of area health planning agencies shall be invited, as appropriate, to serve on committees established by the office and the commission relative to the duties and responsibilities of area health planning agencies. Members of the standing committees shall serve without compensation, but shall be reimbursed for any actual and necessary expenses incurred in connection with their duties as members of these committees.
- Whenever the office or the commission does not accept the advice of the other body on proposed regulations or on major policy issues, the office or the commission shall provide a written response on its action to the other body within 30 days, if so requested.
- The commission or the office director may appeal to the Secretary of Health and Welfare over disagreements on policy, procedural, or technical issues.

History of Accomplishments

- The CHPDAC held hearings; created committees to advise on the health information needs for purchasers and payers, policymakers, providers, and consumers; and reviewed activities that supported the creation and birth of the MIRCal online data collection system.

- The CHPDAC hopes to expand the MIRCal system to include data from emergency departments and ambulatory surgery from hospitals and freestanding ambulatory surgery centers, after the regulations are adopted.

Connecticut Office of Health Care Access (COHCA)

Purpose

The purpose of the COHCA is to design and direct health care system development, advising Executive and Legislative Branch policy makers on health care issues, and informing the public and industry of statewide and national trends.

Mission

The mission of the Office of Health Care Access (OHCA) is to ensure that the citizens of Connecticut have access to a quality health care delivery system.

Composition

The OHCA is led by 1 commissioner that is appointed by the Governor. The powers of the office shall be vested in and exercised by a commissioner who shall have (1) a graduate degree and (2)

a minimum of ten years' experience in the field of financial management, health insurance, hospital administration or a combination of such experience.

The Office of Health Care Access consists of the following three programs:

The Office of the Commissioner:
The Office of the Commissioner provides the overall leadership to the agency in addition to managing the public and government relations at the state, municipal and federal levels with both the legislative and executive branches. The Office of the Commissioner is also responsible for the coordination of all media, public relations, and consumer inquiries.

The Certificate of Need & Compliance Unit:
This unit is responsible for the agency mandates related to hospital and health care expenditures. It serves as the primary activity center for carrying out state statutes and regulations. The Certificate of Need & Compliance Unit consists of the following major functions: Certificate of Need (CON); compliance (monitoring and enforcement of CON decisions); financial oversight of acute care hospitals and forecasting financial and utilization trends; and analysis for the administration of the Uncompensated Care Program.

The Research & Planning Unit:
Unit responsibilities include agency research and planning activities related to the state's acute care hospitals: developing a state health facilities plan, administering the inpatient discharge database, developing and implementing regulations regarding the collection of additional health care utilization data, and creating and implementing the agency communications plan. This unit also oversees the HRSA State Planning Grant, using federal funds to conduct planning activities related to expanding access to affordable health insurance coverage. Research and Planning efforts include monitoring the health policy environment and fostering interagency policy and planning initiatives.

Authority

Created in 1994, the Office of Health Care Access (OHCA) derives its authority primarily from Chapter 368z of the Connecticut General Statutes. The Office constitutes a successor agency to The Commission on Hospitals and Health Care. The powers of the Office are vested in and exercised by a commissioner, appointed as provided in section 19a-612 of the Connecticut General Statutes.

Scope of Authority

- The Office of Health Care Access is generally empowered to exercise specified grants of authority over the creation, maintenance, and operation of such facilities and entities for the furnishing of health care as are provided for in Chapter 368z of the Connecticut General Statutes. The Office administers statutes concerning, but not limited to, health care facility and institution rates, budgets, net revenue limits, capital expenditures, the introduction of additional functions or services, the termination of a health service, the substantial decrease in bed capacity, the acquisition by a person or entity of major medical or imaging equipment or a linear accelerator with a value over the statutory threshold amounts, the reporting of data, the disclosure of information concerning affiliates, and hospital discount policies and agreements.

- Collecting patient-level outpatient data from health care facilities or institutions, as defined in section 19a-630;
- Establishing a cooperative data collection effort, across public and private sectors, to assure that adequate health care personnel demographics are readily available; and
- Performing the duties and functions as enumerated in subsection (b) of this section.

    - The office shall:
        - Authorize and oversee the collection of data required to carry out the provisions of this chapter;
        - Oversee and coordinate health system planning for the state;
        - Monitor health care costs; and
        - Implement and oversee health care reform as enacted by the General Assembly.

    - The Commissioner of Health Care Access or any person the commissioner designates may conduct a hearing and render a final decision in any case when a hearing is required or authorized under the provisions of any statute dealing with the Office of Health Care Access.
    - The office shall monitor graduate medical education and its sources of funding and shall annually

        - Review the financial implications of such education for hospitals, and
        - Evaluate the effect of such education on

            - Access to health care, and
            - Sufficiency of the health care provider workforce. The office shall create an advisory council to advise the commissioner on graduate medical education. For purposes of this subsection, "graduate medical education" means the formal clinical education and training of a physician or other health care provider that follows graduation from medical school and prepares the physician or health care provider for licensure and practice.

    - Not later than January 1, 2000, and annually thereafter, the office shall submit a report on its findings and recommendations to the joint standing committee of the General Assembly having cognizance of matters relating to public health, in accordance with the provisions of section 11-4a.

History of Accomplishments

- In 2006, OHCA processed over 150 Certificate of Need applications from hospitals, surgical facilities, providers and other healthcare facilities.

- During 2006, the Certificate of Need management team attended a CON working session of the CON regulated states in Boston. It was the first time Connecticut's Certificate of Need program

has shared experiences, thoughts and future trends in the health care environment with other CON states.

- Through grant-funded data collection, research and analysis activities, OHCA data collection and analysis provided background for health reform discussions in the executive and legislative branches during 2006. OHCA worked within the political and economic environment to support the development of cost-effective policy options to increase health care coverage in the state, especially for low-income, working uninsured families.

- OHCA released numerous publications and reports in 2006 on a variety of topics including hospital financial stability, uninsured hospitalizations, pediatric psychiatric beds, and uninsured survey results.

- In 2006, OHCA leadership and staff presented research findings to the Medicaid Managed Care Council, and participated on a significant number of committees including the Child Poverty and Prevention Council, Health Care Cost Containment Committee, Committee to Examine Hospital Inpatient Behavioral Health Bed Capacity for Children, Behavioral Health Partnership, and Connecticut Interdisciplinary Health Policy Team.

Delaware Health Care Commission (DHCC)

Purpose

The purpose of the DHCC is to review and make policy recommendations to promote 100% access to health care services, promote a comprehensive health care system assuring quality care, and promote a regulatory and financial framework to manage the affordability of health care.

Mission

To promote accessible, affordable, quality health care for all Delawareans.

Objectives

- Access- Promote access to health care for all Delawareans.
- Quality- Promote a comprehensive health care system assuring quality care for all Delawareans.
- Cost- Promote a regulatory and financial framework to manage the affordability of health care.

Composition

The DHCC has 11 members—4 government officials including the Secretary of Finance, Secretary of Health and Social Services, Secretary of Children, Youth and Their Families and the Insurance Commissioner, and 6 private citizens appointed either by the Governor, the Speaker of the House or the President Pro Tempore of the Senate. The composition is a balance between the executive and legislative branches of government and the public and private sectors. Since 1995, the Commission has used a committee system as a consensus building process tool to assess the impact of its decisions.

The DHCC oversees five major initiatives to meet its mission and objectives:

(1) Uninsured Action Plan – exploring strategies to preserve and expand health insurance coverage through the State Planning Program and linking uninsured citizens with reliable health homes and affordable care through the Community Healthcare Access Program (CHAP).
(2) Information & Technology – creating a statewide clinical information sharing utility through the Delaware Health Information Network (DHIN).
(3) Health Professional Workforce Development – assuring an adequate supply of health care professionals through the State Loan Repayment Program and the Health Workforce Data Committee and expanding educational opportunities for Delawareans through the Delaware Institute of Medical Education and Research (DIMER) and the Delaware Institute for Dental Education and Research (DIDER).
(4) Research & Policy Development – performing ongoing research and providing accurate information for state policy-makers.

(5) Specific Health Care Issues & Affiliated Groups – addressing specific health care conditions that are so prevalent they warrant special attention and working in cooperation with other bodies created by the state for this purpose.

Authority

The DHCC was created in 1990 by the Delaware General Assembly under Title 16 of the Delaware Code as an independent policy setting body, and may call upon the Department of Health and Social Services, the Department of Services for Children, Youth and Their Families, the Insurance Department and/or the Department of Finance for any assistance, information or data that may be necessary to carry out the purposes for which it has been established.

Scope of Authority

- The Commission is expressly authorized to conduct pilot projects to test methods that will move forward private-sector activities that will help the state meet its health care needs. The Commission is authorized to hire staff, contract for consulting services, conduct any technical and/or actuarial studies which it deems to be necessary to support its work, and to publish reports as required in order to accomplish its purposes.
- Determine, in conjunction with the State's Health Statistics Center, the additional data needed to carry out its mission, evaluate the effectiveness of pilot programs, preparing appropriate legislation to obtain such data, and ensure that data to support the goals of health access is available and accessible.
- Recommending methods to reduce and control health care costs in conjunction with the private sector.
- Coordinate efforts with the Health Resources Management Council, which is responsible for overall health planning and the State's Certificate of Need Program, to ensure that Delaware has a balanced approach to access, quality and costs of health care.
- Review and recommend changes to state medical insurance regulations (in conjunction with the Insurance Commissioner) to promote efficiency, equity and affordability in health care insurance premiums.
- Explore all potential insurance options including size and makeup of risk groups.
- Study and make recommendations as to incentives to ensure that employers continue to provide health insurance coverage
- Study and make recommendations regarding benefits to be covered by health plans that would be available through the health care access programs, including prevention, well-child care and prenatal care.
- Identify cost savings to public programs that would result from implementation of health care access programs.
- Study alternative financing plans for the state share of premium costs for those who cannot afford health insurance or who are unemployed.
- Examine and make recommendations focused on access to health care services and various benefit and service packages for a minimum care coverage plan.
- Examine and study actuarial analyses, sliding fee scale analyses, co-payment levels and limits on provider reimbursements and covered services in developing proposals for core benefit packages.

- Develop a methodology to coordinate the health care access program with other government-subsidized programs.
- Conduct other activities it considers necessary to carry out the intent of the General Assembly as expressed in 67 Del. Laws, c. 334, § 1; 70 Del. Laws, c. 516, § 2; 73 Del. Laws, c. 4, § 2.

History of Accomplishments

In 1996, the Commission assumed administrative responsibility for the Delaware Institute of Medical Education and Research, which serves as an advisory board to the Commission. Placing the administration of DIMER within the Commission enhanced its ability to accomplish its primary goal of providing Delaware residents greater opportunity for a medical education, while also expanding its mission to help the state meet its broader health care needs.

In 1997, the Commission assumed responsibility for the creation and maintenance of the Delaware Health Information Network (DHIN). The DHIN is a public instrumentality of the state charged with the design, operation and maintenance of facilities for public and private use of health care information. A community-based health information network for communicating patient clinical and financial information, the DHIN's purpose is to increase the efficiency and quality of health care in Delaware.

Delaware Health Education Pipeline Study and Report - April 2007: This study of health education and training programs is the first of its kind in Delaware, and is intended to provide baseline information that will be useful to policymakers and education leaders in the state. All health programs in the state, a total of 104 programs at over 20 institutions of higher education, were surveyed in 2006 with a near 90 percent response rate. The survey tool was designed to ascertain program composition, current enrollment levels and characteristics, graduation levels, occupation characteristics of graduates, barriers to growth, and future challenges of health education programs in Delaware as they relate to the preparation of a strong health workforce.

Georgia Health Strategies Council (GHSC)

Purpose

The Health Strategies Council is responsible for developing Georgia's State Health Plan and addressing policy issues concerning access to health care services. The council focuses on providing policy direction and health planning guidance for the Division of Health Planning and the Department of Community Health.

Composition

The members of the GHSC are appointed by the Governor and represent a wide range of health care and consumer interests.

26 members representing:

- Health care needs of small businesses-1 member
- Rural hospitals-1 member
- Health care providers-9 members
- Private insurance industry-1 member
- Urban hospitals-1 member
- County government-1 member
- Large business personnel-1 member
- Representatives for the health care needs of different population groups-8 members
- 3 members at large

The GHSC regularly convenes committees of advocates and technical experts to advise members on health plan changes and improvements. Currently there are six advisory committees:

- Indigent and Charity Care Ad Hoc Committee: The Health Strategies Council has recommended the establishment of an Ad Hoc Committee to review current definitions associated with financial information from healthcare providers and to provide the Department with suggested definitions that would provide uniformity and equity for facilities concerning the calculation and reporting of indigent and charity care in the State of Georgia.

- Ambulatory Surgery Services Technical Advisory Committee: The current state health component plan and rules governing the need for and operation of ambulatory surgery services were adopted in 1998. The guidelines address multi-specialty and limited-purpose free-standing ambulatory surgery. The vast majority of physician owned, single purpose surgical centers are exempted from the guidelines by law. Since the inception of the current component plan, concern has risen about the need methodology, the planning areas, the adverse impact on other providers, and the scope of the plan. DCH Board Members and a wide range of stakeholders have suggested that the plan needs to be reviewed and updated.

- Inpatient Physical Rehabilitation Services Technical Advisory Committee: The current State Health Plan and Rules that govern the need for and expansion of Inpatient Physical Rehabilitation Services in the State of Georgia were adopted by the Health Strategies Council

(Council) in 1994. During the annual review of the Department's Certificate of Need Rules by the Council's Long Term Care Standing Committee, it was recommended that both of these documents be reviewed to ensure that they better address the needs of patients, consumers, regulators, and purchasers and reflect current industry practices.

- Psychiatric & Substance Abuse Services Technical Advisory Committee: During the 2004 and 2005 annual review of the State Health Plan and Rules for Psychiatric and Substance Abuse Services by the Acute Care Standing Committee of the Health Strategies Council, it was recommended that the State Health Plan and Rules governing Psychiatric and Substance Abuse Services should be updated given the age of these planning documents and due to recent changes to the Plan and Rules governing Short Stay General Hospital Beds.

- Positron Emission Tomography Services Technical Advisory Committee: The current State Health Component Plan and Rules that govern the need for and expansion for Positron Emission Tomography (PET) Services in the State of Georgia were adopted by the Health Strategies Council in 2002. In 2005, during the annual meeting of the Special and Other Services Standing Committee, the members of the committee recommended that a Technical Advisory Committee be formed to review the rules for this service. The Technical Advisory Committee is charged with reviewing the rules to ensure that they adequately address the concerns of mobile PET providers as well as the needs of patients, consumers, regulators, and purchasers.

- Stereotactic Radiosurgery Technical Advisory Committee: Currently, there are no rules or a State Health Plan for Stereotactic Radiosurgery. Upon approval by the Health Strategies Council, a Technical Advisory Committee has been formed to address the oversight and administration of this service in the State of Georgia. The committee is charged with reviewing the service to develop rules that address the needs of patients, consumers, regulators, and purchasers and reflect current industry practices.

Authority

Created in December 2004, under O.C.G.A. 31-6-21, the GHSC focuses on providing policy direction and health planning guidance for the Division of Health Planning, the Office of General Counsel, and, where appropriate, the Department of Community Health as a whole.

The GHSC serves as a facilitator and provides a forum for public debate on policy decisions affecting health care and the structure of Georgia's delivery system.

Scope of Authority

- Adopt the state health plan and submit it to the Board of Community Health for approval, and include all of the council's functions that are regularly updated;
- Review, comment on, and make recommendations to the department on the proposed rules for the administration of the law;

- Conduct ongoing evaluation of Georgia's existing health care resources for accessibility, including financial, geographic, cultural, and administrative accessibility, quality, comprehensiveness and cost;
- Study long-term comprehensive approaches to providing health insurance to the entire population; and
- Perform other functions that the department or board may specify for the council.

History of Accomplishments

During FY 2006, The Technical Advisory Committees (TACs) for Psychiatric and Substance Abuse and Inpatient Rehabilitation met and revised rules for Psychiatric and Substance Abuse services, Comprehensive Inpatient Physical Rehabilitation services, Traumatic Brain Injury facilities, and new rules for Long Term Care Hospitals for which the GHSC approved rules submitted by each TAC.

Maryland Health Care Commission (MHCC)

Purpose

The purpose of the MHCC is to Develop and carry out new health policies inclusive of planning for health system needs, promoting informed decision-making, increased accountability, and improved access by providing timely and accurate information on availability, cost, and quality of services to policy makers, purchasers, providers and the public via data gathering, public reporting, planning and regulation. Specifically, the MHCC is responsible for 1) developing a database on all non-hospital health care services; 2) developing a comprehensive standard health benefit plan for small employers; 3) monitoring the fiscal impact of state mandated benefits; 4) developing quality and performance measures for health maintenance organizations; 5) developing quality and performance measures for hospitals, ambulatory care facilities, and nursing homes; 6) overseeing electronic claims clearinghouses; 7) directing and administering state health planning functions to produce the State Health Plan; and 8) conducting the Certificate of Need program for regulated entities.

Vision

The vision of the MHCC is a state in which informed consumers hold the health care system accountable and have access to affordable and appropriate health care services through programs that serve as models for the nation.

Mission

The mission of the MHCC is to plan for health system needs, promote informed decision-making, increase accountability, and improve access in a rapidly changing health care environment by providing timely and accurate information on availability, cost, and quality of services to policy makers, purchasers, providers and the public.

Goals and Objectives

Goal 1: Improve quality of care in the health care industry.

Objective 1: By CY 2004, have all HMOs that have been operating predominantly in Maryland's commercial market for three years be "Star Performers" on at least one performance measure.

Objective 2: In FY 2004, expand information and distribution of hospital, nursing home, and ambulatory surgical facility performance evaluation reporting.

Goal 2: Improve access and affordability of health insurance.

Objective 1: In FY 2004, complete timely analysis of the social, medical, and fiscal impact of mandated health insurance benefits and report findings.
Objective 2: Improve access to health insurance in the small group market.

Goal 3: Reduce the costs of health care expenditures.

Objective 1: Improve understanding of health care spending patterns.

Objective 2: Eliminate unnecessary administrative expenses through electronic data interchange (EDI).

Objective 3: Educate private sector payers and providers on the efficient acquisition, development, and distribution of information technology for Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliance.

Goal 4: Ensure that the State Health Plan provides a framework for guiding the future development of services and facilities regulated under the Certificate of Need program.

Objective 1: Annually update the appropriate State Health Plan Chapters.

Objective 2: Ensure that the Certificate of Need (CON) program functions as an effective health policy and planning tool.

Composition

The MHCC has 15 Members appointed by the Governor with the advice and consent of the Senate, for a term of four years. Of the 15 members, 9 members cannot have any connection with the management or policy of a health care provider or payer. The 6 remaining members are represented by 2 physicians, 2 payers (defined in § 19-132), 1 nursing home administrator in the state, and 1 non-physician health care practitioner. Of those appointed by the governor at least 5 members must represent residents of different counties with a population of 300,000 or more, and 3 members are residents of different counties with a population of less than 300,000. Of the members representing a population of less than 300,000 at least 1 resident must reside in Eastern

Shore, 1 resident in Allegany County, Garrett County, Washington County, Carroll County, or Frederick County, and 1 resident in Southern Maryland. To the extent practicable, assure geographic balance and promote racial, ethnic, and gender diversity in the Commission's membership.

The commission is organized around the health care systems that are targeted for evaluation, regulation, or influence through a wide range of tools (data gathering, public reporting, planning and regulation) to improve quality, address costs, or increase access. To achieve this end, the commission oversees five centers:

- Center for Hospital Services
- Center for Long-term and Community-based Care
- Center for Healthcare Financing and Health Policy
- Center for Information Services and Analysis
- Center for Health Information Technology

The MHCC is administered by an Executive Director and 3 Deputy Directors (DD). Each DD is responsible for 4 divisions:

- *Health Resources*: acute and ambulatory care services, specialized health care services, long term care and mental health services, certificate of need program staff.
- *Performance and Benefits*: benefits analysis, special projects, HMO quality and performance, and facility quality and performance.
- *Data Systems and Analysis*: data base and application development, cost and quality analysis, EDI programs and payer compliance, network operations and administration systems

Authority

Created in 1999, the MHCC operates under Subtitle 1 of Title 19 of the Health General Article in the Maryland Annotated Code. The Maryland General Assembly established the MHCC as a public, regulatory commission by merging the Health Care Access and Cost Commission and the Maryland Health Resources Planning Commission.

Scope of Authority

(1) Develop health care cost containment strategies to help provide access to appropriate quality health care services for all Marylanders, after consulting with the Health Services Cost Review Commission;

(2) Promote the development of a health regulatory system that provides, for all Marylanders, financial and geographic access to quality health care services at a reasonable cost by:

    a. Advocating policies and systems to promote the efficient delivery of and improved access to health care services; and

b. Enhancing the strengths of the current health care service delivery and regulatory system;

(3) Facilitate the public disclosure of medical claims data for the development of public policy;
(4) Establish and develop a medical care data base on health care services rendered by health care practitioners;
(5) Encourage the development of clinical resource management systems to permit the comparison of costs between various treatment settings and the availability of information to consumers, providers, and purchasers of health care services;
(6) In accordance with Title 15, Subtitle 12 of the Insurance Article, develop a uniform set of effective benefits to be included in the Comprehensive Standard Health Benefit Plan;
(7) Analyze the medical care data base and provide, in aggregate form, an annual report on the variations in costs associated with health care practitioners;
(8) Ensure utilization of the medical care data base as a primary means to compile data and information and annually report on trends and variances regarding fees for service, cost of care, regional and national comparisons, and indications of malpractice situations;
(9) Establish standards for the operation and licensing of medical care electronic claims clearinghouses in Maryland;
(10) Reduce the costs of claims submission and the administration of claims for health care practitioners and payers;
(11) Determine the cost of mandated health insurance services in the State in accordance with Title 15, Subtitle 15 of the Insurance Article;
(12) Promote the availability of information to consumers on charges by practitioners and reimbursements from payers; and
(13) Oversee and administer the Maryland Trauma Physician Services Fund in conjunction with the Health Services Cost Review Commission.
(14) The Commission shall coordinate the exercise of its functions with the Department and the Health Services Cost Review Commission to ensure an integrated, effective health care policy for the State.

History of Accomplishments

Policy Changes and Reforms:

- Reforms in the small group market have led the MHCC to complete a six month reform process including six community meetings across the state culminating in a new Comprehensive Standard Health Benefit Plan – greater flexibility, more choices, lower base price, including the introduction of an HMO plan and the participation of the major insurer Aetna.

- The Certificate of Need Task Force considered ways to streamline the CON process via a series of changes in statute, regulation, and day-to-day practice; almost all of these changes are already underway.
- Promoting Electronic Health Records and Secure Health Information Exchange by staffing the Task Force on the Electronic Health Record, established by the General Assembly and appointed by the Governor; conducting a study to identify barriers to appropriate information exchange in Maryland and to develop strategies to address privacy and security, and collaborating with the Health Services Cost Review Commission in funding, through a competitive process, several $250,000 projects to plan and then a $10 million project to implement the first phase of a state-wide health information exchange.
- Providing consumers with better information to make better choices through quality reporting using objective measures, patient and family satisfaction measures, and the Price Transparency Project that will soon publish prices for common physician services (both billed amounts and allowed amounts) by county, specialty, and specific service, giving the 25th, 50th, and 75th percentiles.
- Reports that help guide policy include an annual report on health care expenditures in Maryland, an analysis of the problem of the uninsured in Maryland, a summary of insurance coverage in the state, and special studies of importance to policymakers, including prescription drug spending, uncompensated care, and primary care services.

New Mexico Health Policy Commission (NMHPC)

Purpose

Develop a plan and monitor the implementation of state health policy by providing independent research, guidance, and recommendations on health policy issues that impact the planning of health care and health systems for New Mexico, as well as a being a major forum for the discussion of complex and controversial health policy and planning issues including the interrelations with education, the environment and economic well-being.

Vision

The NMHPC will help New Mexican's improve their health status by being the State's trusted advisor on health policy issues.

The Commission will:

- Be valued by peers, colleagues and consumers for its independence and expertise;
- Provide leadership in identifying and researching critical health and health care delivery issues;
- Provide policy research and recommendations to the legislative and executive branches of state government; and
- Maintain a work environment that encourages individual growth and teamwork.

Mission

The NMHPC is a state agency that provides independent research, guidance and recommendations on health policy issues that impact the health status of New Mexicans.

Objectives

- Contribute to and advance best practices
- Collaborate with other state and health care agencies
- Promote the agency's role as a researcher and catalyst
- Enhance the NMHPC's databases to serve as a source of planning for healthcare and health systems

Composition

The NMHPC, administratively attached to the Department of Finance and Administration, consists of 9 members appointed by the governor with the advice and consent of the Senate to reflect the ethnic, economic, geographic and professional diversity of the state. No member of the commission shall have a pecuniary or fiduciary interest in the health services industry for 3 years preceding their appointment to the commission. 2 members shall be appointed for 1 year terms, 3 members appointed for 2 year terms, three members appointed for 3 year terms and all subsequent appointments shall be made for 3 year terms.

The NMHPC now has a decentralized organization with appropriate staff members organized under 4 work units – information technology, program, administration, and economic research.

Authority

The NMHPC was created in 1991 as an independent state policy setting body, and is directed by two statutes: *New Mexico Health Policy Commission: Section 9-7-11.1 through 9-7-11.2 NMSA 1978* and *Health Information System Act: Section 24-14A-1, NMSA 1978*.

Scope of Authority

In general, the NMHPC is responsible for three overarching functions:

(1) Health Policy - Macro-level systems analysis, planning and formulation of policy recommendations.
(2) Health Information Systems - The HIS Act reinforces the necessity of data collection as a means to facilitate or enable a statewide health plan, but also introduces two other data gathering priorities: Support for state government health resource planning and consumer information.
(3) Health Information Alliance - The HIA was established by statute under the HIS Act as a joint public-private initiative to develop a statewide health information network to reduce duplicative data collections and reporting.

The specifically defined functions of the Commission include:

- Obtain and evaluate factors that affect the availability and accessibility of health services and health care personnel in the public and private sectors.
- Perform needs assessments and make recommendations regarding the training, recruitment, placement and retention of health professionals in underserved areas of the state.
- Establish a process to prioritize recommendations on program development, resource allocation and proposed legislation.
- Prepare and publish an annual report describing the progress in addressing the state's health policy and planning issues.
- Distribute the annual report to the governor, appropriate state agencies and interim legislative committees and interested parties.
- Provide information and analysis on health issues to facilitate the synthesis of health policy in the public and private sectors and respond to requests by the executive and legislative branches of government.

History of Accomplishments

- The NMHPC is responsible for the publication of *Quick Facts*, the annual *County Financing of Health Care,* the annual *New Mexico Consumer Guide to Managed Care, Hospital Inpatient Discharge Data Reports,* and *Geographic Access Data System Report*.

- The NMHPC participated in task force and workgroups including the Cultural Competence Education in the Health Sciences Task Force, the Regional Health Information Organization Steering Committee, the Telehealth Commission and Alliance, the Interagency Behavioral Health Purchasing Collaborative and Behavioral Health Planning Council, and the Women's Health Advisory Council.

- Participated in the third annual Physician Workforce Research Conference sponsored by the Association of American Medical Colleges, the Annual Health Provider Retreat sponsored by New Mexico Health Resources.
- Participated in Governor Richardson's Higher Education Summit sponsored by the New Mexico Higher Education Department.

North Carolina Medical Care Commission (NCMCC)

Purpose

To adopt, recommend or rescind rules for regulation of most health care facilities (hospitals, hospices, free standing outpatient surgical facilities, nursing homes, home care agencies, home health agencies, nursing pools, facilities providing mammography/pap smear services, free standing abortion clinics, ambulances, and emergency medical services personnel).

To administer the Health Care Facilities Finance Act; which enables NCMCC to issue tax-exempt revenue bonds to finance construction and equipment projects for nonprofit and public hospitals, nursing homes, continuing care facilities for the elderly and facilities related to the foregoing.

Composition

The NCMCC has seventeen members appointed by the Governor. The 17-member Commission was incorporated into the Department of Health and Human Services. Three members of NCMCC are nominated by the North Carolina Medical Society, one by the North Carolina Pharmaceutical Association, one by the North Carolina State Nurses' Association, one by the North Carolina Hospital Association, and one by the Duke Endowment. Each nomination is subject to the Governor's approval. In addition, ten members, one of whom must be a dentist, are appointed by the Governor. Each member is appointed to a four-year term and memberships are staggered. NCMCC is attached organizationally to the Department of Health and Human Services, Division of Facility Services, and is staffed by that Agency.

Pursuant to the Executive Organization Act of 1973, the 17-member Commission was incorporated into the Department of Health and Human Services.

Authority

Created in 1946, under the Hospital Survey and Construction Act (Hill-Burton), the NCMCC was a result of the findings of the North Carolina Hospital and Medical Care Commission, a special commission appointed in 1944 to study the critical shortages in general hospital facilities and trained medical personnel in the State of North Carolina and to make recommendations for improvements in these areas. Among the recommendations made was that the legislature provide for a permanent State agency that would be responsible for the maintenance of high standards in North Carolina's hospitals, and the administration of a medical student loan fund, and a statewide hospital and medical care program.

Scope of Authority

The NCMCC was established in 1945.

1. The NCMCC has the duty and power to promulgate, adopt, amend and rescind rules in accordance with the laws of the State regarding the regulation and licensing or certification,

as applicable, of hospitals, hospices, free standing outpatient surgical facilities, nursing homes, adult care homes, home care agencies, nursing pools, facilities providing mammography/pap smear services, free standing abortion clinics, ambulances and emergency medical services personnel.

2. In 1975, the North Carolina General Assembly enacted the Health Care Facilities Finance Act, which enables NCMCC to issue tax-exempt revenue bonds to finance construction and equipment projects for non-profit and public hospitals, nursing homes, continuing care facilities for the elderly and facilities related to the foregoing.
3. Make a survey of the hospital resources of the State and formulate a statewide program for construction and maintenance of local hospitals, health centers and related facilities, and receive and administer federal and State Funds appropriated for such purposes
4. Make loans to medical students
5. Survey all factors concerning the location of the expanded university medical school. (The same act authorized the expansion of the University of North Carolina Medical School from a two-year to a four-year program).

History of Accomplishments

Health Care Facilities Finance Act: Passed by the General Assembly in 1975 in order to provide an alternative means of financing health care facility construction and modernization. The Act authorizes the NCMCC to review applications by a public or nonprofit agency, and to issue tax-exempt revenue bonds and notes, and lend the proceeds to the applicant. Bonds are sold through the North Carolina Local Government Commission (the "LGC") and are retired from loan payments made by the applicant.

North Dakota State Health Council (NDSHC)

Purpose

The State Health Council serves as the North Dakota Department of Health's advisory body.

Composition

The council's 11 members are appointed by the governor for three-year terms. Four members are appointed from the health-care provider community, five from the public sector, one from the energy industry and one from the manufacturing and processing industry.

The governor may select members to the council from recommendations submitted by trade, professional, and consumer organizations. On the expiration of the term of any member, the governor, in the manner provided by this section, shall appoint for a term of three years, persons to take the place of members whose terms on the council are about to expire. The officers of the council must be elected annually. Any state agency may serve in an advisory capacity to the health council at the discretion of the council.

Authority

Created by North Dakota legislation - NDCC § 23-01-02

Scope of Authority

- Monitor overall health care costs and quality of health care in the state
- Recommend to the appropriate interim legislative committees changes to the health care system in the state
- Establish standards, rules, and regulations which are found necessary for the maintenance of public health, including sanitation and disease control
- Make rules and regulations for the government of the council and its officers and meetings, including the time and place of meetings of the council
- Establish standards, rules, and regulations which are found necessary for the maintenance of public health, including sanitation and disease control
- Provide for the development, establishment, and enforcement of basic standards for hospitals and related medical institutions which render medical and nursing care (including construction and maintenance of such institutions) to cover matters pertaining to sanitation, building construction, fire protection measures, nursing procedures, and preservation of medical records.

    - No rule may be adopted with respect to building construction of existing medical hospitals or related medical institutions unless the rule relates to safety factors or the hospital or related medical institution changes the scope of service in such a way that a different license is required from the department pursuant to rules adopted under chapter 23-16.

- Hold hearings on all matters brought before it by applicants and licensees of medical hospitals with reference to the denial, suspension, or revocation of licenses and make appropriate determination as specified herein. The council may direct the state health officer to do or cause to be done any or all of the things which may be required in the proper performance of the various duties placed upon the state department of health.
- At any time that the health care needs of a city, township, or other geographic area are not being adequately met, any person may apply to the state health council for approval to conduct an alternative health care services pilot project. The application must address the need for and benefits of the pilot project. It must also contain a detailed description of the nature and scope of the project, quality control, organization, accountability, responsibility, and financial feasibility.

    - Upon receipt of an application under subsection 1, the state health council shall schedule a public hearing, send notice to all interested parties, and give public notice of the hearing by publication in the official newspaper of each county in the pilot project area. At the hearing, the council shall accept written and oral testimony. The council shall review the application and all testimony presented at the hearing and approve, disapprove, or modify and approve the application based on criteria established by the council. The criteria must address the availability and use of health personnel, facilities, and services

- Notwithstanding any other provisions of law, upon approval of an application submitted under subsection 1, the state health council, in consultation with the state health officer and any other public or private entity consulted by the state health council, shall set the standards for the delivery of health care services by the pilot project. The standards may not adversely affect the state's participation in federal Medicare and Medicaid programs. No more than three separate projects may be operational at any time and no project may be operational for longer than five years.

History of Accomplishments

N/A

Oregon Health Policy Commission (ORHPC)

Purpose

Develop and oversee health policy and planning for the state by identifying and analyzing significant health care issues affecting the state, and make policy recommendations to the Governor, the Oregon State Legislature and the state Office for Oregon Health Policy and Research (OHPR). The OHCC also partners with health care experts and stakeholders around the state to develop projects which ensure access to essential health care and support services, increase health care quality and improve health outcomes for individuals and society, control costs, and encourage healthy lifestyles.

Mission

The mission of the OHCC is to develop and promote policy recommendations to the Governor, the Oregon State Legislature, and OHPR that improve the health of all Oregonians by ensuring access to essential health care and support services, increasing quality and improving outcomes for individuals and society, controlling costs, and encouraging healthy lifestyles.

Goals

- Assure all Oregonians access to essential health care services
- Produce quality outcomes and information that promote informed decision-making by providers and consumers
- Be adequately financed and efficiently operated to ensure affordability and sustainability
- Encourage healthy lifestyles through education and incentives
- Foster collaboration among public and private entities

Principles for Reform

- Simplify the system. Unnecessary complexity leads to confusion, cost, and errors.
- Invest in prevention. Investing scarce dollars to prevent injury and disease, rather than merely treating it when it occurs, will produce the greatest return.
- Manage chronic and catastrophic care. Only ten percent of our population is responsible for 69% of health care costs. To control costs, we need to better manage treatments for the chronically and catastrophically ill.
- Align incentives. Consumers and providers must have incentives to make health care decisions that drive quality and control cost.
- Increase transparency. Patients, providers, and employers need appropriate information in order to make informed decisions and drive quality through the health care system
- Maintain a broad and strong safety net. Over the past few years, Oregon's safety net infrastructure has been stretched thin.
- Achieve access for all Oregonians through rational coverage decisions. To stay within budget constraints, it is better to place limitations on the services covered rather than deny people insurance coverage.

- Focus on children. Providing health care to children provides an excellent return on investment.

Composition

Administered through the Office for Oregon Health Policy & Research, the OHPC has 10 voting members appointed by the Governor and 4 legislators that serve as non-voting advisory members; members represent all of the state's congressional districts and bring a rich variety of health policy and health care experience.

The OHPC has established workgroups to assist with its mandated duties. Each work group focuses on a specific topic, issue, or policy:

- Quality & Transparency (2005 and 2007)
- Delivery System Models (2005 and 2006)
- Quality & Transparency (2006)
- Childhood Obesity Study - Research/Science Workgroup (2006)
- Childhood Obesity Study - Practitioner/Policy Workgroup (2006)
- Electronic Health Records & Data Connectivity Subcommittee (2004 and 2005)
- Healthy Oregon (2005)
- Access (2004)
- Cost (2004)
- Quality (2004)
- Health Status (2004)

Authority

The OHPC was created in 2003 under HB 3653, passed by the Oregon General Assembly. The OHPC is authorized to establish subcommittees and may appoint advisory committees to advise it in carrying out its duties.

Scope of Authority

- Act as a policy-making body for a statewide data clearinghouse
- Review Office for Oregon Health Policy and Research (OHPR) reports
- Provide a forum for discussion of health policy and health care issues
- Identify and analyze significant health policy and health care issues affecting the state and make recommendations to the Governor
- Prepare and submit to the Governor and Legislative Assembly resolutions relating to health policy and health care reform
- Review proposed policy modifications to the state's Medicaid program
- Act as primary advisory committee to OHPR, the Governor and the Legislature

History of Accomplishments

Road Map for Health Care Reform: Creating a High-Value, Affordable Health Care System and *Covering the Uninsured: The Cost to Oregon* (companion document) (2007): The Governor directed the OHPC to develop recommendations for establishing an affordable and sustainable health care system that is accessible to all Oregonians. This report outlines OHPC's proposed plan, which is aimed at achieving universal coverage while minimizing disruption of the existing insurance market. One aim of this report is to provide estimates of the cost of coverage under the OHPC plan. In addition, we hope that this report also serves as a resource for policy makers by providing a common set of assumptions about the number of uninsured, commercially insured, and publicly insured individuals in Oregon, as well as the health care spending associated with each group.

March 2005 Oregon Health Policy Commission Report (2005): The OHPC Subcommittee on Electronic Health Records (EHR) and Data Connectivity was formed to develop recommendations for 1) fostering the adoption of EHR and 2) developing the infrastructure for the secure exchange of electronic health data in Oregon. This report outlines the Subcommittee's recommendations on the appropriate role for government, in conjunction with the private sector, to further these efforts. The OHPC and the Subcommittee intend for these recommendations be used to further discussion with state legislators, providers, and other stakeholders to move the state's health information technology forward.

END**NOTES**

[i] All information was obtained from the California Health Policy and Data Advisory Commission website at http://www.oshpd.ca.gov/Boards/CHPDAC/index.html, and California Codes: Health and Safety Code, Section 128675-128810 obtained from http://www.oshpd.ca.gov/Boards/CHPDAC/TextPDFfiles/CHPDACH&SCode.pdf.

[ii] All information obtained from the State of Connecticut Office of Health Care Access website at http://www.ct.gov/ohca/site/default.asp; Office of Health Care Access Act, 6 Conn. Stat. Title 19a Health and Wellbeing, ch. 368z § § 19a-610 - 19a-689 obtained from http://www.cga.ct.gov/2005/pub/Chap368z.htm; Connecticut Office of Health Care Access. (2007). *Annual Report to the Governor and Legislature*.

[iii] All information obtained from the Delaware Health Care Commission website at http://dhcc.delaware.gov/default.shtml and Delaware Code Title 16 Health and Safety, Chapter 99 Delaware Health Care Commission retrieved from: http://delcode.delaware.gov/title16/c099/index.shtml#P-1_0.

[iv] All information obtained from the Georgia Health Strategies Council website at http://dch.georgia.gov/00/channel_title/0,2094,31446711_32561170,00.html; Health Strategies Council of Georgia. (2006). *Annual Report Fiscal Year 2006*. Georgia Department of Community Health. Obtained from http://dch.georgia.gov/vgn/images/portal/cit_1210/42/49/70398315HSC_Annual_Report_FY2006%20.pdf.

[v] All information obtained from the Maryland Health Care Commission website at http://mhcc.maryland.gov/.

[vi] All information obtained from the New Mexico Health Policy Commission website at http://hpc.state.nm.us/; New Mexico Health Policy Commission (2007). *Annual Report SFY 07* obtained from http://hpc.state.nm.us/documents/Annual%20Report%20SFY%2007.pdf.

[vii] All information obtained from the North Carolina Medical Care Commission website at http://www.ncdhhs.gov/dhsr/ncmcc/index.html.

[viii] All information obtained from the North Dakota State Health Council website at www.health.state.nd.us.

[ix] All information obtained from the Oregon Health Policy Commission website at http://www.oregon.gov/OHPPR/HPC/index.shtml.