



## STATES' ROLES IN SHAPING HIGH PERFORMANCE HEALTH SYSTEMS

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**ABSTRACT:** States shape the health system in many ways, influencing key components such as insurance coverage, quality of care, and information and provider infrastructures. This report presents findings from the State Health Policies Aimed at Promoting Excellent Systems project, undertaken by the National Academy for State Health Policy, with support from The Commonwealth Fund. After conducting surveys of multiple agencies in states across the country, as well as a review of related literature, this study found that states are pursuing system improvements across the full spectrum of their authority, including health care purchasing, regulation of providers, reporting of performance data, integration of public health with health care approaches, and improving the availability and affordability of health insurance. Despite this activity, this study finds room for states to do much more. Ongoing efforts to track, study and diffuse information on state activities could accelerate adoption of promising policies and practices.

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## EXECUTIVE SUMMARY

States shape the health system in many ways, determining or influencing key system components such as insurance coverage, quality of care, and information and provider infrastructures. They affect these components in their roles as purchasers, regulators, analysts, planners, collaborators, and conveners, as well as providers of information and technical assistance. Despite this activity, there is little systematic effort to monitor states, learn from their choices, and spread innovations from state to state. In addition, coordination between states and the federal government is often lacking.

This report presents findings from the State Health Policies Aimed at Promoting Excellent Systems (SHAPES) project, undertaken by the National Academy for State Health Policy (NASHP), with support from The Commonwealth Fund, to identify and spread information about state health policies and practices aimed at promoting high performance health systems. The project was guided by the following principles, which are based on the key attributes of high performance as defined by the Commonwealth Fund Commission on a High Performance Health System:

- States can work toward the goal of ensuring that everyone has equitable and affordable coverage of essential health care services.
- States can strive to ensure that everyone receives the right care at reasonable cost; this care should be equitable, safe, patient-centered, and coordinated.
- States can help develop and improve health system infrastructure to ensure that everyone has access to health services that promote long and healthy lives.

### **Noteworthy Findings**

States are pursuing system improvements across the full spectrum of their authority, including health care purchasing, regulation of providers, gathering and analyzing of performance data, and efforts to expand the availability and affordability of health insurance. Using surveys of six state agencies as well as a review of other state survey reports, this study revealed a great deal of variation in states' involvement in such efforts across the country.

#### *Health Insurance Coverage*

States can play a major role in ensuring affordable health coverage, not only by maximizing the use of federal programs, but by going beyond them with state-only investments and public–private approaches.

Federal financial support is most available for children, and many states are working to extend that support to cover all children. This study also confirmed that states are working to cover adults. Medicaid generally does not provide funding for states to provide coverage to healthy, working adults without children, so states must obtain federal waivers to cover them. Seventeen states have such waivers. In addition, at least two states (Washington and Pennsylvania) are using state funding, with no federal financial assistance, to cover childless adults.

Some states also promote coverage for childless adults through programs aimed at expanding coverage for small employers. Nearly three-quarters of the states that responded to NASHP's surveys indicated they have policies or programs aimed at reducing the cost of coverage for small employers and their workers. Twelve states reported they use premium assistance; six reported they have reinsurance programs; four reported they have purchasing pools; and 24 states responded they use other types of programs. These alternative strategies include state tax credits to make coverage more affordable for small employers, allowing small businesses and self-employed people to form purchasing alliances, allowing insurers to sell plans with reduced benefits, and regulating rates in the small group market.

States also are exerting influence over insurance benefit design—not only in public coverage programs, but also in the private marketplace—by defining minimum benefit packages and requiring parity in mental health coverage. To streamline public coverage enrollment and renewal, states are using technology, but there is significant potential for them to do more in this area.

### *Quality, Safety, and Value*

States are engaging in collaborative efforts to improve quality of care, both with the private sector and in cross-agency efforts. States are using a variety of levers as purchasers, including requiring reporting on quality, employing specific contractual provisions for vulnerable populations, and having joint quality requirements in multiple-agency purchasing.

In particular, public reporting is a critical ingredient for system accountability. It can generate interest in improvements to maximize quality, safety and efficiency, and is a necessary tool for consumer choice. Over half of states that responded to the SHAPES survey are publicly reporting quality data or patient safety data or both kinds of data. Most, but not all, of these states have legislative mandates requiring such reporting.



### *Health System Infrastructure*

Information is an essential element in maintaining and improving health systems, and technology offers increasingly sophisticated tools for information collection, maintenance, and exchange. Over half of responding public health agencies and governors' offices reported that their states have a public health information system that integrates data from multiple sources. Immunization data and vital statistics data were most commonly included in these systems, followed by hearing screenings, laboratory data, newborn screenings, hospital discharge information, and cancer registry data. The primary users of these data systems are public health agency employees, followed closely by employees in other state agencies and private sector health care providers. Only seven states reported public use of the data.

States are addressing health system provider capacity by monitoring the safety net, addressing provider shortages, and reimbursing for telehealth. A number of states cited collaborative relationships with other entities in these efforts, including primary care associations that represent community health centers.

### **Takeaway Messages**

- States' multiple roles in the health care system create opportunities for promoting performance; many states avail themselves of these opportunities.
- Every state reported some activity that promotes achievement of a high performance health system.
- States continue to focus strongly on securing insurance coverage and access to health care services for vulnerable populations.
- States are moving beyond historic roles to exert influence with the private insurance market, leverage purchasing power, and collaborate more with the private sector.
- Few states are actively pursuing system performance in areas such as efficiency and patient safety.
- In every area examined, there is room for states to do more in pursuit of a high performing health system.
- Ongoing mechanisms to monitor, study, and report state activities could help diffuse and speed adoption of promising policies and practices.

- More in-depth exploration of specific areas of state activity could yield richer information that would aid state and national efforts to improve system performance.
- Opportunities for state-to-state exchange could help transfer knowledge and experience and spark new and innovative approaches through joint state problem-solving.

A more extensive report of survey findings and other data is available at [www.nashp.org/files/shapes\\_report.pdf](http://www.nashp.org/files/shapes_report.pdf).

# **STATES' ROLES IN SHAPING HIGH PERFORMANCE HEALTH SYSTEMS**

## **INTRODUCTION**

Health system performance is the result of many elements. State policies represent one—but certainly not the only—factor in achieving results. The *State Scorecard on Health System Performance*, released by the Commonwealth Fund Commission on a High Performance Health System in 2007, documented great variation across states in access, quality, avoidable costs, equity and achieving healthy lives. It also illustrated the interrelated nature of these topics—particularly that states with poorer access also demonstrated poorer quality—and the importance of pursuing all aspects of high performance simultaneously.

This report is a product of the State Health Policies Aimed at Promoting Excellent Systems (SHAPES) project, undertaken by the National Academy for State Health Policy (NASHP), with support from The Commonwealth Fund. The project was guided by the following principles, which are based on the key attributes of high performance as defined by the Commonwealth Fund Commission on a High Performance Health System:

- States can work toward the goal of ensuring that everyone has equitable and affordable coverage of essential health care services.
- States can strive to ensure that everyone receives the right care at reasonable cost; this care should be equitable, safe, patient-centered, and coordinated.
- States can help develop and improve health system infrastructure to ensure that everyone has access to health services that promote long and healthy lives.

In September 2006, NASHP sent six different surveys (with some common and some unique questions in each of these three areas of inquiry) to state agencies responsible for Medicaid, insurance, State Children's Health Insurance Program (SCHIP), public health, state employee benefits, and governor's health policy in each of the 50 states and the District of Columbia. The survey questions were developed to solicit information in important areas of state health policy and practice relevant to high performance health systems, based on literature review and input from project advisors. Follow-up was targeted to Medicaid, SCHIP, and state employee benefit agencies because they tend to have the greatest involvement in the policies and practices covered by this report. All 51 jurisdictions responded with at least one agency survey. The overall response rate was 52 percent of the 291 surveys fielded.

The study methodology and data collection strategy were developed through a structured process informed by an advisory group and a review of evidence linking health policies and practices to health system performance. Survey questions designed to elicit information on state policies and practices were developed where existing data sources were unavailable.

The breadth of the SHAPES survey, the variability in agency responses, and the response rate all suggest caution in interpreting results. Despite these limitations, certain key themes emerged, from which findings and conclusions were drawn. By examining promising practices and the effects of specific state policies, this report can help states move toward a high performing health system. A more extensive report of survey findings and other data is available at [www.nashp.org/files/shapes\\_report.pdf](http://www.nashp.org/files/shapes_report.pdf).

## **HEALTH INSURANCE COVERAGE**

Headlines from Maine, Massachusetts, Vermont, California, Illinois, Pennsylvania, and other states have highlighted the fundamental role states can play in ensuring that affordable health insurance options are available for residents. While not every state is working on an ambitious plan to cover all uninsured people, all states are working to reduce the ranks of the uninsured. States can ensure that coverage is affordable by expanding public coverage, like Medicaid and SCHIP, above and beyond federal requirements; creating public–private partnerships designed to enhance the availability of coverage; and regulating and monitoring the private health insurance marketplace. States also can create systems to keep people continuously covered by improving outreach, enrollment, and retention in public programs. Finally, states can take action to ensure that people receive necessary benefits.

### **Ensuring Affordable Coverage**

The SHAPES study confirmed that states are using many of their powers to work toward the goal of attaining affordable health coverage for everyone. The Commission on a High Performance Health System has underscored the importance of universal coverage, affordability, and equity in access to care, and has identified expanding insurance coverage as a necessary—although not sufficient—step toward achieving these system characteristics.<sup>1</sup> States are working to take this step by playing a role in collecting and analyzing data to understand problems and needs; convening stakeholders to forge solutions; developing and enacting legislation; and administering, financing, and regulating health insurance coverage.

All states have leveraged federal Medicaid and SCHIP resources to provide coverage for their residents. Most have exceeded minimum federal requirements for covering some eligible groups: children, parents, pregnant women, the elderly, and people with disabilities. As of July 2006:

- Through Medicaid and SCHIP, 41 states covered children in families with incomes that are 200 percent or more of the federal poverty level, far exceeding federal requirements; and
- Thirty-seven states covered pregnant women with incomes at 185 percent of the federal poverty level or higher, even though they are required to cover only those with incomes at 133 percent of the poverty level or below.

Federal requirements and options for coverage have placed priority on covering children, and to a lesser extent, pregnant women. While most states have exceeded coverage minimums for these groups, a minority—16 states—have used Medicaid or SCHIP to cover parents with incomes at or above the poverty level.

Many states have gone beyond minimum federal policy and financial incentives to provide public coverage for people who ordinarily do not qualify for Medicaid or SCHIP. These groups include childless adults, legal immigrants who have not been in the country for at least five years, and uninsured children in families with incomes that exceed standard SCHIP levels. States successfully pursued various strategies to cover some of these populations, as follows:

- Seventeen states had federal waivers to cover childless adults in Medicaid or SCHIP, and two more states (Washington and Pennsylvania) covered such adults using 100 percent state funding;
- Seventeen states reported they provide some coverage for legal immigrants who have been in the country for less than five years and do not qualify for federally funded Medicaid or SCHIP;
- In 32 states, there were programs that allow people with disabilities to buy in to the Medicaid program to retain coverage they would otherwise lose if they return to work or work more hours than allowed to retain disability related income payments;
- More than a dozen states allowed specific groups, such as local government employees, school districts, small businesses, nonprofits, and foster-care parents, to buy in to the state employee health plan; and
- Seven states had created SCHIP buy-in programs.

Many states also had programs that combined public funds with employer, philanthropic, or individual contributions. Additionally, nearly three-quarters of the states that responded to NASHP's surveys indicated that they had policies or programs aimed at reducing the cost of coverage for small employers and their workers. Twelve states reported they used premium assistance; six reported they had reinsurance programs; four reported they had purchasing pools; and 24 states responded they used other types of programs. These alternative strategies included state tax credits to make coverage more affordable for small employers, allowing small businesses and self-employed people to form purchasing alliances, allowing insurers to sell plans with reduced benefits, and regulating rates in the small group market.

***Massachusetts: Affordable and Simpler Coverage for Everyone***

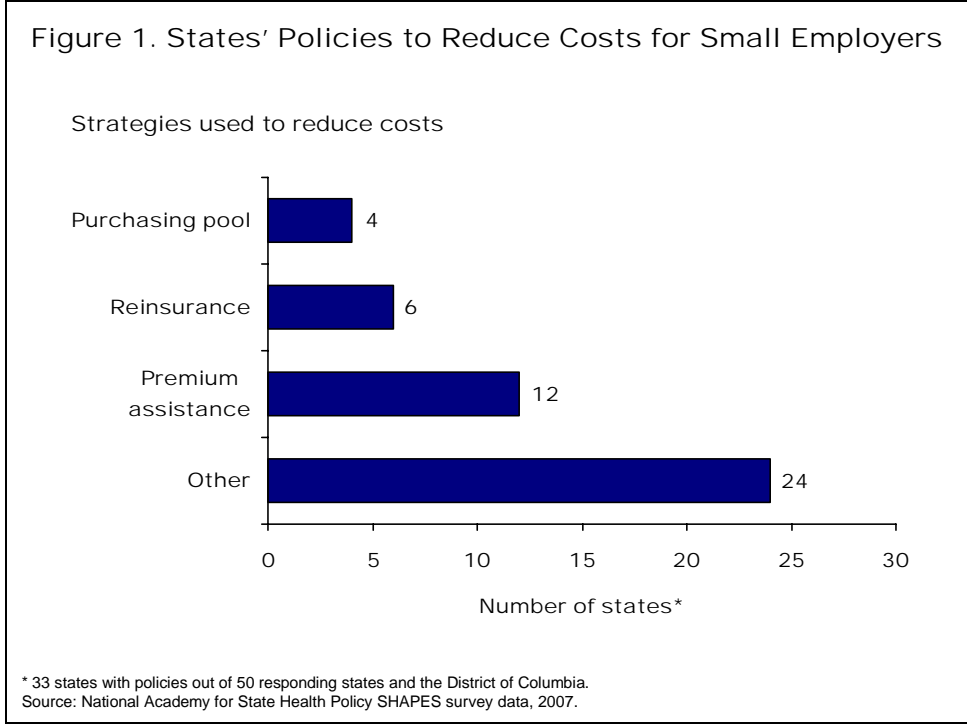
Providing affordable coverage is a key component of Massachusetts's recent health reform, which includes an individual mandate to buy health insurance. Uninsured residents (i.e., citizens and legal immigrants) falling below 300 percent of the federal poverty level now qualify for some type of subsidized insurance. They can enroll in coverage either through MassHealth (the traditional Medicaid and SCHIP program) or Commonwealth Care, a tiered insurance product with benefits and cost-sharing requirements that vary by income and is delivered by the same managed care organizations as MassHealth. To simplify enrollment, the programs all use a single application and the MassHealth agency reviews all applications to determine qualification.

This approach of a common eligibility ceiling and system avoids the confusion that comes with complicated federal Medicaid categories under which children, pregnant women, parents, and others are eligible at different levels of income. The Massachusetts approach allows families and adults to more easily identify themselves as eligible and enroll in coverage.

The financing structure and new eligibility groups resulted from Medicaid waiver negotiations with the federal government. Massachusetts was in danger of losing \$385 million in federal matching funding that it had previously received to support safety net hospitals. The waiver agreement allowed the state to redirect those funds to purchase coverage for individuals.

People with incomes above 300 percent of poverty are expected to buy insurance on their own. However, to assist with affordability, new insurance products will be offered through the state's new Connector agency, or through employers.

Sources: *Massachusetts Medicaid SHAPES survey and the Commonwealth Connector Web site, <http://www.mass.gov/?pageID=hichomepage&L=1&LO=Home&sid=Qhic>*

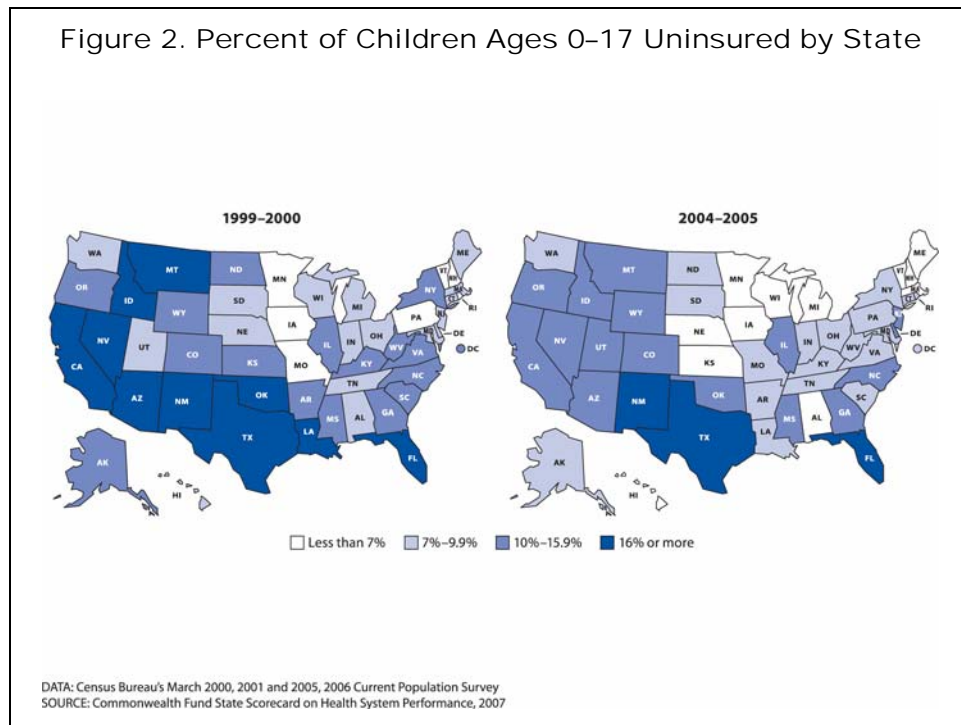


States also can address affordability through regulation of the small group and individual health insurance marketplace. One form of state regulation is guaranteed issue of policies—meaning no applicant can be denied an offer of coverage due to health status, employment sector, or other characteristics. Another form of state regulation is rate restrictions, which limit the additional premium that can be charged individuals or groups due to expected higher risk. Both types of regulation can help people who have health conditions that may make it difficult for them to obtain affordable coverage or any coverage at all. Federal law requires that small group plans be guaranteed issue; fourteen states reported to NASHP that they also require private health insurance to guarantee issue to self-employed individuals. Six states reported that they require health insurance to be guaranteed issue for individuals who are not self-employed. While nearly all states have some type of rate restrictions in the small group market, only sixteen reported that they restrict rates in the individual market.

Finally, states play an important role by collecting and analyzing data on health insurance coverage. Over half of states regularly collect such data from household or employer surveys. Most use the data for planning and policy development, and also disseminate the information to the public. These data have helped states develop health reform plans, requests for waivers from particular federal policies, and strategies to address disparities among groups. States also use the data to identify underserved areas

needing health care safety net programs. Many states also collect data on trends in employer coverage.

National data confirms the strides that states have made in covering children with the help of programs like SCHIP. The Commonwealth Fund's *State Scorecard* documented the positive trend in children's coverage across states, even at a time when the rate of uninsured adults was rising.



However, the most recent census data show the U.S. continues to lose ground on coverage, among both adults and children. From 2005 to 2006, the total percent of people in the U.S. who were uninsured rose by half a percentage point, from 15.3 percent to 15.8 percent (44.8 million to 47.0 million), and the percent of uninsured children rose by nearly a full percentage point, from 10.9 percent to 11.7 percent (8.0 million to 8.7 million).<sup>2</sup> The employer and economic forces driving these trends transcend state boundaries, and suggest that despite their efforts and previous successes in expanding coverage, states alone cannot assure that everyone in the U.S. has affordable coverage. National support and strategies also are needed.



## **Streamlining Enrollment and Renewal**

Although expanding options for affordable coverage is a big challenge in achieving universal coverage, many uninsured people are eligible for free or low-cost public coverage but are not enrolled. Among uninsured children, as many as three of four are estimated to be eligible for Medicaid or SCHIP but not enrolled. Reasons include lack of knowledge about available programs, as well as complex forms and procedures for enrollment and renewal.<sup>3</sup>

States trying to achieve universal coverage for children have noted that sending the message that every child is eligible is itself a successful marketing tool for encouraging enrollment.<sup>4</sup> In addition to outreach and marketing strategies, states have worked to simplify eligibility systems, policies, and procedures. Most SCHIP programs have continuous eligibility policies that allow children to remain eligible for up to one year despite any family income fluctuations. Smaller numbers of states are using administrative renewal processes that require little if any information or action on the part of families. These state agencies use collected data to send preprinted forms that need be returned only if there are changes. Some verify continuing eligibility by matching information with other state databases (such as tax records) that have current information.

While much of the work to streamline eligibility has focused on efforts to cover children or pregnant women, some states have put simpler and faster processes in place for people needing long-term care services. States have piloted use of presumptive eligibility—a policy option most often used for children and pregnant women—for this population. Individuals are assumed eligible based on simple enrollment criteria, and are covered for services while the complete application is processed. At least eight states have piloted fast-track eligibility decisions, which allow the agencies responsible for long-term care services to make eligibility decisions.

Most states use technology to make enrollment or renewal easier. Automation does not solve all the barriers to application and enrollment, such as complicated eligibility rules and documentation requirements, which may be set by federal policy. However, automation offers the potential for greater ease and efficiency.<sup>5</sup> In 38 out of 41 states that responded to this part of the SHAPES survey, applications for Medicaid or SCHIP are available online. However, in most cases, the application cannot be submitted or processed online. Only a few state programs, such as Pennsylvania SCHIP, allow online renewals. This system accepts electronic signatures, and the state is working on ways to allow income verification documentation to be submitted online.

### ***Utah: Integrating Online Program Applications***

Applying for programs like Medicaid can be a cumbersome, time-consuming, and confusing process. Utah Clicks is an innovative online resource that makes applying for state aid easier by reducing the burden on families applying for state programs, as well as providing an integrated front-end interface for various types of assistance that are often disconnected. The Web site—[www.utahclicks.org](http://www.utahclicks.org)—allows families to learn about and apply for programs including Medicaid, Head Start, and SCHIP, 24 hours a day, seven days a week, in Spanish or English. The site receives a substantial number of applications after normal business hours.

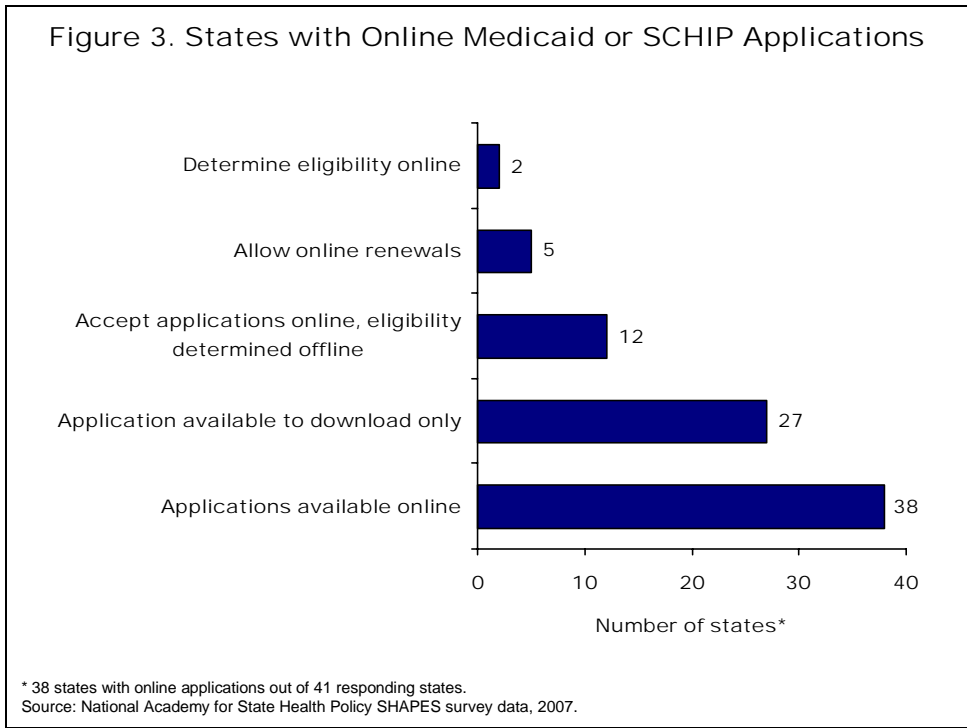
Questions that are shared across program applications, like family income, are grouped by topic and only asked once, avoiding unnecessary duplication. The individual applications are then referred to the appropriate staff for an eligibility determination. The system allows both intake workers and applicants to review and make changes to documents online, reducing printing and postage costs, as well as processing time.

The software was developed by researchers at the Utah State University under a four-year, \$600,000 grant from the federal Maternal and Child Health Bureau, and it has received a 2006 Innovation Award from the Council of State Governments. Utah State University has already entered into partnership with Oregon and Indiana, and is in negotiations with other states to license the Universal Application System software that powers Utah Clicks.

Utah is also implementing other information technology tools to enhance its enrollment and renewal operations, including an Electronic Resource and Eligibility Product (eREP) that automates back-end eligibility determination for multiple programs.

*Source: Council of State Governments, 2006 Innovation Awards Program Application, <http://ssl.csg.org/innovations/2006/2006winnersalternates/utahclicks.pdf.pdf>, 2006 Innovation Awards presentation, <http://www.csg.org/programs/innov/documents/UtahClicks.ppt> and Utah Medicaid SHAPES survey response.*

States are working to link their online application systems to other health and human service programs; 16 states reported such linkages.



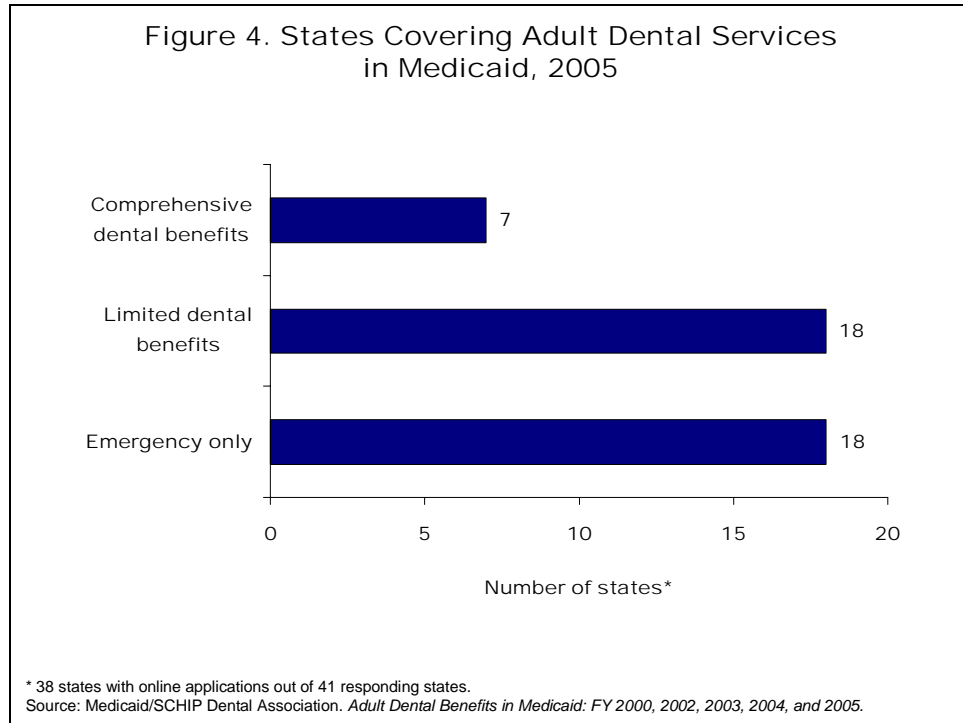
### Designing Benefit Packages

The Commonwealth Fund’s Commission on a High Performance Health System has emphasized the importance of getting the “right health care”—that is, care that is known to be effective, as needed for prevention, treatment, or to alleviate pain or symptoms. The right care is an essential ingredient of quality health care. Established benefits allow people to obtain the right care.

States have substantial authority to establish benefits for public coverage programs. While Medicaid and SCHIP each have minimum requirements for benefit packages, states can and do go beyond these minimums. Because required benefits for children are well established, this report examined an optional benefit for adults under Medicaid—dental care.

Infections from lack of adequate oral health care can lead to costly or catastrophic outcomes. Infections can spread through the bloodstream, leading to hospitalization or death. Additionally, emerging research indicates a correlation between gum disease and systemic conditions like pre-diabetes and heart disease, as well as pneumonia among nursing home residents.<sup>6</sup> Some dental services are covered for adults in most states, although they are a frequent target for cuts when budgets are tight. Seven states offer comprehensive adult dental benefits and include coverage of preventive care (e.g., routine

cleanings) and restorative services (e.g., fillings).<sup>7</sup> Eighteen states offer adult dental benefits that are limited in scope or have a yearly dollar cap.<sup>8</sup> An additional 18 states cover only emergency services, most frequently defined as coverage of tooth extractions and care that relieves pain.<sup>9</sup>



Mental health services represent another area of unmet need. Health plans often provide less coverage for mental health care and substance abuse treatment than for other health conditions. States can prohibit insurers from discriminating between mental and physical disorders by passing mental health parity laws; 38 states have done so.<sup>10</sup> Research has shown that mental health benefits can be offered on par with other medical services without significantly increasing health insurance premiums.<sup>11</sup>

### ***Benefit Standards and Competing Concerns in Maryland***

Small employers often lack the bargaining power that bigger firms enjoy when it comes to buying health insurance products for their employees. Maryland is one of several states that regulate the small-group health insurance marketplace by setting a minimum benefit package that insurers competing in this market must offer. In doing so, the state faces difficult choices between competing priorities.

The Maryland Health Care Commission manages the Comprehensive Standard Health Benefit Plan, which sets the minimum standards for benefits, cost-sharing, and premiums in the Maryland small-group market. Approximately 40 percent of Maryland's 127,000 small employers (that is, employers with between two and 50 employees) buy into the nine participating health plans, which provided coverage for 448,000 people in 2005. The standard plan is comprehensive, covering most services, including organ transplants. Insurers must offer modified community rating, meaning a member's premiums cannot be adjusted according to health status or any characteristic other than age and geography. Employers are permitted to buy riders for benefits that go beyond the standard plan, but the additional benefits must enrich the plan.

Standard plan premiums must be set at less than 10 percent of the average Maryland wage. If the value of the standard plan exceeds this limit, the Commission is required to modify the standard benefit plan to meet this criterion. In an environment where health care costs are increasing more rapidly than wages, this creates a tension between affordability and scope of coverage. In 2006, the Commission struck a balance between these two competing concerns by revising the pharmacy coverage standards to essentially maintain catastrophic coverage for generic and brand-name drugs, with a \$2500 annual deductible for single coverage, a \$5000 deductible for family coverage, and coinsurance allotting members responsibility for 75 percent of drug costs. Employers are still free to enter into riders for more generous pharmacy coverage.

*Sources: Maryland Insurance SHAPES survey response, Maryland Health Care Commission Summary of Carrier Experience, Year Ending December 31, 2005: [http://mhcc.maryland.gov/health\\_insurance/financialrpt06.pdf](http://mhcc.maryland.gov/health_insurance/financialrpt06.pdf), Maryland's Comprehensive Health Benefit Plan for Small Employers (brochure): [http://mhcc.maryland.gov/smallgroup/cshbp\\_brochure.pdf](http://mhcc.maryland.gov/smallgroup/cshbp_brochure.pdf)*

States can influence benefits provided through the private health insurance market. Of the 34 states that responded to this question, 18 reported that they require a minimum benefit package for the individual or small group market. While several noted that the packages were based on national recommendations, such as National Association of Insurance Commissioners model laws, most indicated that the packages were based on state advisory group input. A smaller number of states indicated that they monitor trends in private insurance products, for internal, planning, or public dissemination purposes.

### **QUALITY, SAFETY, AND VALUE**

States have many opportunities to improve quality and patient safety and safeguard the public. As regulators and as purchasers of health care, states can use their influence to establish expectations; gather and analyze information needed to identify problems and their causes; and require, encourage, and reward efforts to improve quality and patient

safety. States also can encourage transparency through public reporting to drive quality improvement, reward high-quality safe performance and encourage correction of poor performance through purchasing decisions, coordinate state agency efforts, and partner with the private sector on quality initiatives.

### **Collaborating to Improve Quality of Care**

Many different state agencies—including professional licensure boards, licensure and certification agencies, Medicaid, insurance, and public health departments—can have an impact on health care quality, using tools related to their roles as regulators, purchasers, or providers of health care. However, without a vehicle to organize quality-related activities, state efforts may be fragmented. Some states have developed health care quality agendas, collaboratives, or other forums to craft coordinated strategies; 11 of 33 states that responded to this part of the survey have done so.

A state's leverage to drive quality improvements and efficiencies in the health care system may be enhanced by partnering with the private sector. Of the states responding to the survey, 21 have joined public-private initiatives to address and coordinate quality and patient safety activities. States play active roles in these partnerships, including coordinating and facilitating meetings and workgroups, and providing funding and technical assistance. Most of the collaboratives coordinate public and private activities and many provide information and education for consumers. Most have focused on issues of clinical effectiveness (i.e., whether particular treatments or interventions work) and efficiency (i.e., achieving quality while restraining costs). Fewer have focused on patient satisfaction or other issues. At least six states have enacted legislation supporting the creation of patient safety centers, designed to house and coordinate statewide patient safety activities.<sup>12</sup>

### ***Collaboration as an Iterative Process in Oregon***

The Oregon Health Policy Commission was created by the Oregon Legislature in 2003 as a public body to develop and oversee health policy for the state. The Commission, however, does not work alone in this effort. It has engaged the participation of many people in the years since its inception. The new statewide strategic health plan, a draft of which was made public in March 2007

(<http://www.oregon.gov/DAS/OHPPR/HPC/docs/2007/roadmaptoreformdraft.pdf>), seeks to create a high-value health system by improving health information technology, broadening and sustaining health coverage, and improving the quality of health care services. In crafting this plan, the Commission drew on the expertise of a variety of stakeholders, including the Commission's Quality and Transparency Workgroup, a 23-member panel of representatives from private insurance, public sector insurance, academia, and service providers. This workgroup meets regularly to discuss recommendations on subjects like electronic health records, confidentiality of patient records, and disseminating quality information.

The Oregon Health Care Quality Corporation—a collaborative led by a board of public and private health sector stakeholders—participates in the Quality and Transparency workgroup and has been a leader in the effort to develop commonly used evidence-based measures for improving the treatment of conditions like asthma, cardiovascular disease, diabetes, and depression. The Department of Human Services partnered with the Quality Corporation to pilot a Chronic Disease Clearinghouse to collect claims data and feed quality measures back to providers. Lessons learned from that experience are being applied statewide. The Oregon's Governor's Office reports it is considering a request for information and cost assessment to implement the measures.

*Sources: Oregon Governor's Office SHAPES survey response, the Oregon Health Policy Commission Web site, <http://www.oregon.gov/DAS/OHPPR/HPC/index.shtml>, and the Oregon Health Care Quality Corporation, <http://www.q-corp.org/>.*

### **Publicly Reporting Performance Data**

Public reporting of data that measure aspects of system performance is necessary to reach and sustain excellence. It is a critical ingredient for system accountability and can generate interest in improvements to maximize quality, safety, and efficiency. Publicly reported data are a necessary tool to aid consumers in making important health care decisions.

Over half of states that responded to the survey are publicly reporting quality data, patient safety data, or both kinds of data. Sixteen of these states have legislative mandates that require such reporting.

Data is generated from payers and providers. Five states require all health care payers to supply quality data to states; only one requires all payers to provide patient safety data to the state for public reporting.

More commonly, providers—hospitals in particular—are providing the quality and patient safety data for state public reporting. Hospitals most often provide data on

inpatient care, less often on outpatient and emergency room care. Data are most likely to be drawn from hospital discharge data rather than paid claims data or medical chart reviews. Fewer states report publicly on health plan, physician, nursing home, ambulatory surgical center, community health center and local health department quality or patient safety data than on hospital data.

### ***A Multi-Pronged Quality Initiative in Maine***

In Maine's pursuit of quality improvement, it is using measurement, public reporting of data, and identification of high achievers to understand its health care delivery systems and improve outcomes. Several entities provide Maine residents with a wide variety of information on the quality of care provided by the state's doctors, hospitals, and health care payers.

The Maine Quality Forum ([www.mainequalityforum.gov](http://www.mainequalityforum.gov)), established by the state legislature in 2003 as part the health care reform effort, seeks to improve public health care data, promote best practices, and present findings to consumers and the legislature. It reports on geographic variations in 34 different measures of disease prevalence and hospital performance, measuring variations by community on conditions ranging from adult diabetes to knee replacements. In 2006, it launched the In a Heartbeat project to develop a set of evidence-based best practices for fast, effective treatment for patients who are suspected of having suffered a heart attack. It also administers the Safety Star program, which recognizes Maine hospitals that meet thresholds of performance on safety practices, and publicly identifies hospitals that are working to be among the safest.

The Maine Health Management Coalition ([www.mhmc.info](http://www.mhmc.info)), a 34-member coalition of providers, insurers (including the state employee health plan), and public and private employers, seeks to measure and report on the value of health care services. It provides rankings of the state's doctors and hospitals and uses an easy-to-read "blue-ribbon" system to help consumers select health care providers. Its Pathways to Excellence projects seek to identify and reward providers that demonstrate high quality care and reductions in medical errors.

The Maine Health Data Organization (<http://mhdo.maine.gov/imhdo/>) was established by the legislature in 1996 as an independent executive agency with a public-private board. It maintains a publicly accessible database of health information and provides access to quality measures as well as detailed data from hospital and emergency department claims through the HealthWeb for Maine Web site (<http://www.healthweb.maine.gov/>).

*Sources: Maine Governor's Office SHAPES survey response, and agency Web sites noted above.*

States are issuing reports and reporting quality and patient safety data on state Web sites. Some also use media campaigns and toll-free phone lines. Measures to ensure the information is accessible to diverse groups include consumer training, producing reports in multiple languages, and conducting literacy testing of the material.



Most states use nationally recommended measures of quality or patient safety; a smaller number also use state-developed measures. States that report using quality measures say they most commonly focus on clinical effectiveness. Measures of efficiency are not commonly reported by states.

### **Value-Based Purchasing**

Because states purchase health care for a sizable share of the market, they have a significant opportunity to influence its quality and safety. The Medicaid and SCHIP programs spend over \$320 billion per year in state and federal funds. Medicaid and SCHIP are among the country's major purchasers of health care, accounting for one-sixth of all health care spending in the U.S.

Paying for quality is receiving increased attention from both public and private purchasers. Purchasers pay for poor-quality care when insurance costs increase as the result of overuse, underuse, and misuse of health care services. Purchasers can use their leverage instead to improve quality and patient safety by rewarding high-quality, safe performance and encouraging the correction of poor performance. Payment incentives can reward effective and efficient care that focuses on value.<sup>13</sup>

The SHAPES survey of Medicaid, SCHIP, and state employee health plan purchasers asked about states' practices and found a wealth of states using their purchasing power to influence quality. Most state agency contracts (33 of 43 states responding) require reporting on quality measures. Most commonly, states are requiring measures of clinical effectiveness and patient satisfaction, using nationally developed or endorsed measurement sets, particularly the Healthcare Effectiveness Data and Information Set (HEDIS) measures. Many states also use state-developed measures, but few state agencies require reporting on patient safety measures.

Twenty four states reported taking quality-related performance into account when contracting for services, primarily by assigning additional points in the review process. Fewer states take patient safety into account. A small number of states selectively contract based on quality or patient safety.

### ***Stressing Quality Through Contracting in Minnesota***

Minnesota's Quality Care and Rewarding Excellence (QCare) program seeks to realize savings to the public by insisting on stringent quality and safety standards in state health contracts. The program, currently under development, was established by executive order in July 2006. It requires that standards and payment incentives across state agencies, including Medicaid, Minnesota Care, and Minnesota Advantage (the state employee health plan) be aligned to meet benchmarks of improved patient safety and quality of care by 2010.

The initiative sets aggressive goals of improving the quality of care provided to patients for diabetes and cardiac conditions. It also seeks to improve preventive care for adults and children, including bringing rates of immunization, well-child visits, and breast and cervical cancer screening to 90 percent. Hospital safety is addressed through a set of best practices regarding care for all heart attack, heart failure, and pneumonia patients. Hospitals in the top 20 percent will receive payment incentives; after three years, hospitals that fall below minimal benchmarks will face penalties. Provider performance on all measures will be publicly reported on [www.minnesotahealthinfo.org](http://www.minnesotahealthinfo.org).

These contract standards are intended to improve the health of Minnesota patients and engage them in disease-management behaviors, such as the appropriate use of aspirin to manage heart disease, while at the same time helping to control the state's long-term medical costs. In regard to diabetes care, the state anticipates that meeting its goal of having 80 percent of patients receive optimal care, including bringing blood sugar under 8 percent, will save the state \$66 million and reduce the risk of complications from diabetes by 31 percent. The Minnesota Department of Health estimates that if all QCare standards are met, more than \$153 million in health care costs will be saved annually.

*Source: Minnesota State Employee Health Plan SHAPES survey response, QCare Web site, <http://www.health.state.mn.us/healthinfo/qcare.html>, and the Governor's Health Cabinet Web site, <http://www.thehealthcabinet.com/QCare.htm>.*

State governments are responsible for ensuring vulnerable populations have access to health care and utilize those benefits effectively to promote and maintain their health. Federal options and financing are available to support disease or care management or coordination services for vulnerable populations, including children, pregnant women, and individuals with chronic conditions. The SHAPES survey found a majority of states include formal care management services in their health care contracts. Many of these programs are condition-specific, addressing conditions that include asthma, diabetes, developmental delays, lead poisoning, HIV/AIDS, congestive heart failure, hypertension, cancer, chronic pain, and substance use. Some programs are designed for medically complex or dual-diagnosis conditions.

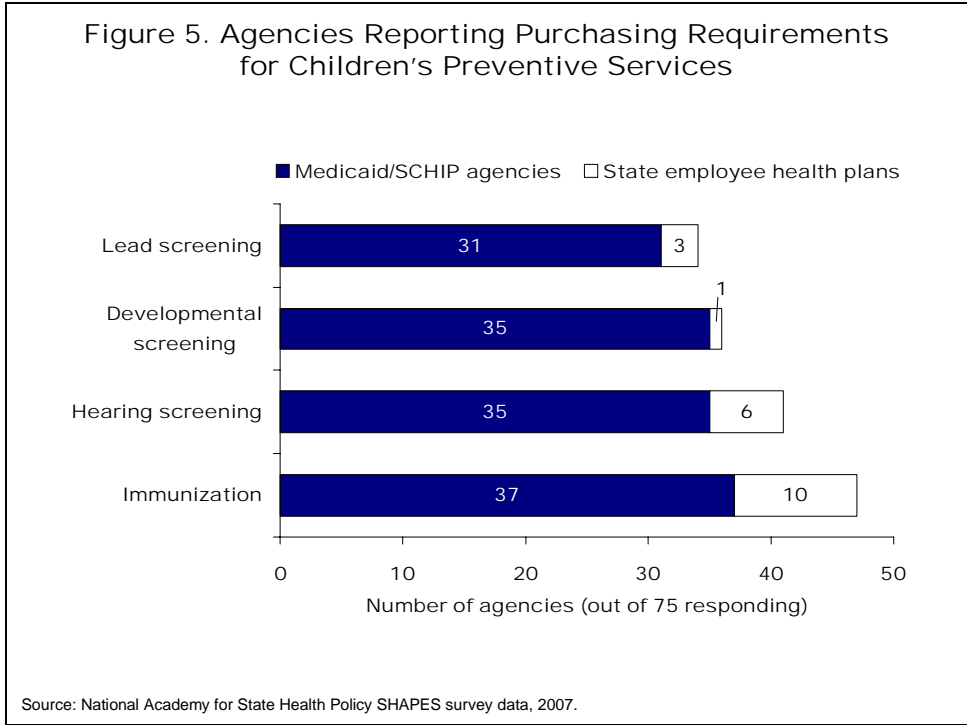
Many Medicaid and SCHIP agencies require that contractors be able to identify vulnerable populations so they can better meet specific needs. Ethnicity or language identification, for example, can help providers address specific cultural and linguistic needs. Among the states responding, the survey identified only one state employee health

plan (Massachusetts) that identifies participants by these characteristics. Many Medicaid agencies, some SCHIP agencies, and the Massachusetts employee health plan also include requirements addressing cultural competency in their contracts.

Many Medicaid and SCHIP agencies also require contractors to identify populations with disabilities or special needs. Many agencies specifically address children with special health care needs, a group that receives special recognition in Medicaid law. Other populations receiving specific attention from states include those with HIV/AIDS, those with mental health conditions, and the homeless. Many Medicaid contracts and some SCHIP contracts also specify requirements for communication capabilities needed by individuals with special needs. No responding state employee health plans reported requiring that special needs populations be identified, but three plans reported communication requirements for them.

State Medicaid and SCHIP agencies also promote quality care when they use a pediatric standard of medical necessity in their contracts. Many of these state agencies use definitions consistent with federal Medicaid requirements that address health maintenance and promotion of growth and development. Only two responding state employee health plans do so.<sup>14</sup>

Medicaid and SCHIP contracts also are more likely than state employee health plans to require preventive services for children. Specific pediatric preventive services are components of Medicaid's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program. Most Medicaid and SCHIP program contracts address immunizations and lead, hearing, and developmental screenings. State employee health plans are most likely to address immunizations and least likely to address developmental screening.



There is clear evidence in the literature that children’s primary care providers who use objective developmental screening tools do a better job of identifying children with potential developmental delays than providers who rely only on clinical judgment.<sup>15</sup> Medicaid and other state agencies can play an important role in promoting system and practice-level changes to improve routine identification of young children with developmental problems. According to the survey results, a minority of state agencies recommends or requires the use of specific developmental screening tools in their contracts. Only 12 Medicaid or SCHIP agencies<sup>16</sup> and no state employee health plans do so.

The SHAPES study also examined the extent to which state agencies leveraged their purchasing power further through joint or coordinated purchasing with other agencies, states, or the private sector. In 29 of 48 responding states, one or more agencies include requirements in their contracts designed to help other state agency programs achieve their goals. For example, agencies incorporate standards developed by other agencies or require that their contractors also contract with other agencies. State agencies commonly participate in joint requests for proposals, and often include shared requirements for quality, or less frequently, for patient safety. While Medicaid and SCHIP agencies most commonly participate in such joint efforts, public health and state

employee health agencies in a number of states are also participating. Some states also noted behavioral health purchasing partnerships.

Among a minority of states engaged in cross-state purchasing arrangements, public health agencies most frequently reported participation. Vaccines, newborn screening, and prescription drugs were cited most often in multi-state purchasing arrangements. Many states are sharing or pooling cost and quality data or research, with fewer sharing information on patient safety. However, such data sharing may be occurring for purposes other than value purchasing, such as creating larger data sets to improve monitoring of quality of care. Intrastate data sharing is less common than interstate sharing. A final but important finding was that 17 states reported participation in public–private health care purchasing initiatives. Many of these initiatives include common requirements for quality reporting and improvement and, again less frequently, for patient safety.

## **HEALTH SYSTEM INFRASTRUCTURE**

States also act to improve system performance by ensuring that key system supports or infrastructures are in place. The system capacities selected for this report include: availability of providers, particularly for underserved populations such as those in rural areas or areas with health provider shortages; health data and information technology (IT) and exchange; and population-based approaches to improving health outcomes. This final capacity is an essential component to achieving the overarching goal of a high performance health system—long, healthy, and productive lives. While state government generally has some role in each of these aspects of system infrastructure, the extent of the role and its relationship to the private sector and to federal and local partners varies.

### **Addressing Health System Provider Capacity**

States play multiple roles to ensure there are sufficient well-qualified providers available and appropriately placed to achieve equitable access to care. These roles include training health professionals; credentialing and licensing providers; structuring and providing reimbursements; monitoring and taking action to address problems such as malpractice, fraud, and abuse; and supplying information to help consumers find and select providers. State governments also often assume special responsibilities in ensuring the availability of providers for vulnerable and underserved populations, an area in which the federal government and communities play a strong role. Vulnerable and underserved populations may include those living in inner city and rural areas that lack sufficient providers; low-income, uninsured, and underinsured populations; children and youth; and individuals

with chronic illnesses and disabilities. The traditional roles states play in promoting access to care are being supplemented or retooled by the availability of new technology.

The SHAPES study selected three areas to explore in regard to policies and practices that promote equitable access to providers: monitoring the status of the health care safety net; addressing health professions shortages; and providing for electronic clinical consultations.

The importance of the health care safety net—and of monitoring its success—is well established. In 2000, researchers at the Institute of Medicine wrote:

*The strength and viability of a community's safety net are highly dependent on state and local support, state Medicaid policies, the structure of the local health care market-place, and the community's economic health. While devolution of responsibilities to state and local governments has encouraged the development of innovative programs to care for the uninsured . . . there is a compelling need for a stronger ongoing capacity to monitor the changing status of the safety net and thus generate adequate data upon which effective policies can be developed.*<sup>17</sup>

The survey asked public health agencies if and how their states were monitoring the status of safety net providers, which deliver a significant level of health care to the uninsured, Medicaid patients, and other vulnerable populations. Fifteen of the 25 responding public health agencies indicated their states were monitoring the status of the safety net. A number of states cited collaborative relationships in these efforts with other entities, including primary care associations that represent community health centers. Some states cited actions resulting from monitoring, such as planning for additional service sites, assisting with applications for federal funding, and increased state funding for the safety net.

### ***Safety Net Monitoring and Surveillance in Missouri***

Community health centers and other safety net clinics provide vital access to health services, but states must know how these services are being used to plan for future needs. The Missouri Department of Health and Senior Services works collaboratively with the Missouri Primary Care Association to collect and report patient demographic data to better assess patient migration patterns. They primarily have used Medicaid payments to Federally Qualified Health Centers to track how patients utilize primary care, dental, and mental health services. Preliminary findings indicate that patients frequently cross county boundaries to access these services. This has highlighted a problem with the use of Medicaid data as a metric of a county's overall health. The county that a Medicaid claim is attached to is based on where the service was provided, and not the county where the patient resides. This could cause the state to overestimate the level of access to scarce services, like dental care, in one county and underestimate the access problems in adjoining counties. The state is working with the Primary Care Association to overcome these issues and refine its picture of health care safety net use in the state.

A related project, the Oral Health Preventive Services program, conducts surveys of the patterns of use of oral health services among the state's children. It collects information on oral health screenings and provision of preventive services like fluoride varnish, an easy-to-apply cavity-fighting paste that is ideal for school-based interventions.

*Sources: Missouri Public Health SHAPES survey response, and Oral Health Surveillance Web site, <http://www.dhss.mo.gov/oralhealth/OralHealthSurv.html>.*

This study also examined the ways states are addressing critical health professional shortages. Such shortages can have a particularly deleterious impact on people who do not have the resources to travel long distances or pay higher rates. The survey examined three types of strategies to address shortages: state funding for scholarship or loan repayment programs; waivers to allow foreign medical graduates to practice; and state policies to expand the scope of practice for non-physician providers such as nurse practitioners, dental hygienists, and social workers. Most of the public health agencies reported employing the first two strategies, while fewer are using the third.

States can help residents overcome distance, transportation, and other barriers to care by supporting the use of electronic consultations in health care delivery, often referred to as telemedicine or telehealth. These terms generally refer to the use of electronic information and telecommunications technologies to improve the delivery of clinical health services.<sup>18</sup> The survey looked at both public and private coverage of telemedicine. About one-third of responding states purchase or reimburse for electronic consultations between physicians and patients. A smaller number of state agencies purchase or reimburse for electronic consultations between specialists and primary care physicians. Very few states require private insurers to purchase or reimburse for

electronic consultations between physicians and patients. Only Minnesota requires insurers to purchase or reimburse for electronic consultations between specialists and primary care physicians, and to purchase or reimburse for electronic monitoring of patients from an off-site location. Three states reported that they require insurers to reimburse for other types of electronic consultations or monitoring. However, it is important to note that insurance companies may be offering coverage for these types of services, even though the state has not required it.

### **Building Information Systems**

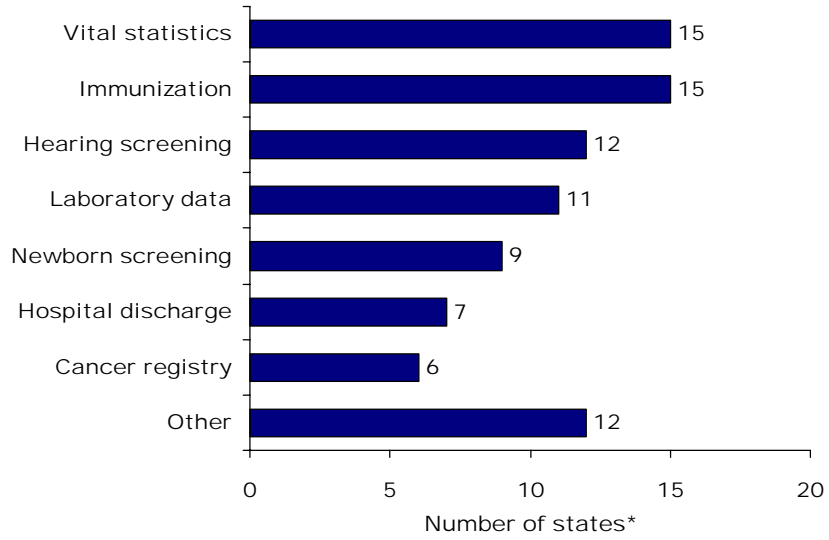
Information is an essential element in maintaining and improving health systems and technology offers increasingly sophisticated tools for information collection, maintenance, and exchange. The Commonwealth Fund Commission on a High Performance Health System has noted that “well-integrated electronic information systems have the capacity to improve the delivery and coordination of care, reduce medical errors, and provide a mechanism for tracking and assessing performance.”<sup>19</sup> While federal and private sector roles in advancing and utilizing new information systems and technologies have received substantial attention in the health field, the roles of states have begun to command attention more recently.

The SHAPES study focused on two areas related to information systems, technology, and information exchange. These include the integration of categorical public health information systems and the role states play in health information exchange and technology.

Over half of responding public health agencies and governors’ offices reported that their states have a public health information system that integrates data from multiple sources. Immunization data and vital statistics data were most commonly included in these systems, followed by hearing screening, newborn screening, hospital discharge, laboratory, and cancer registry data. The primary users of these data systems are employees from public health and other state agencies, but they are also used by private sector health care providers in most states and by the public in a smaller number of states. Public health data sets are useful in examining health outcomes, particularly when matched with utilization data.

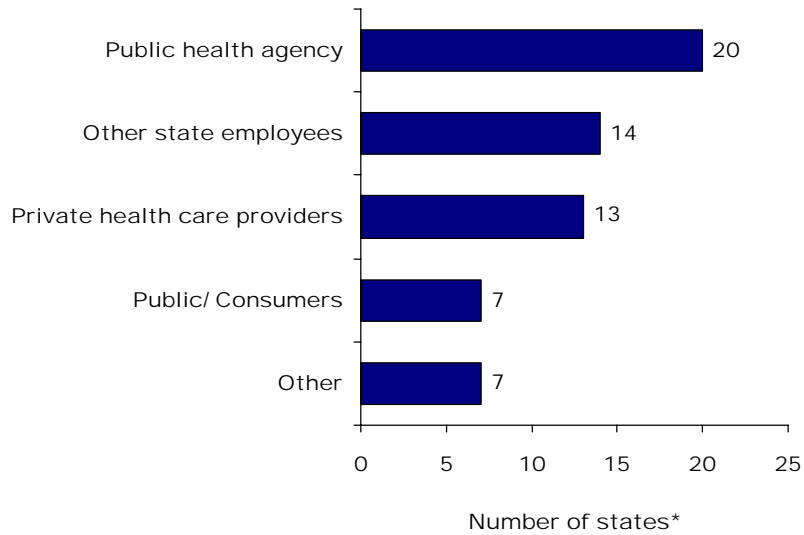


Figure 6. Data Included in Integrated Public Health Information Systems



\* 19 states with integrated systems out of 33 responding states.  
Source: National Academy for State Health Policy SHAPES survey data, 2007.

Figure 7. Use of Integrated Public Health Information Systems



\* 19 states with integrated systems out of 33 responding states.  
Source: National Academy for State Health Policy SHAPES survey data, 2007.

### ***Integrated Public Health Information in Oklahoma***

Oklahoma is developing a Public Health Oklahoma Client Information System (PHOCIS) that will allow the state to draw detailed information from a variety of public health interventions. It will collect demographics, information on population-based services provided by Oklahoma State Department of Health employees, and electronic encounter and outcome records for health services provided by a variety of customers. These customers include schools, day-care centers, hospitals, and other government agencies. The PHOCIS system will also include billing information from Medicaid and Medicare.

This coordination of data will allow analyses of programs like the state's SoonerStart initiative, for example, which provides early intervention services for vulnerable infants and toddlers with developmental delays. SoonerStart can use PHOCIS to access Medicaid claims information to track a child's immunizations, and then use vital records data to determine whether the intervention has been effective in reducing long-term costs and achieving desired outcomes.

Along with PHOCIS implementation, Oklahoma also is engaged in several related projects to move to electronic health records and to integrate tribal, private, and public medical records, which will further enhance the state's ability to monitor and analyze overall health.

*Sources: Oklahoma Public Health SHAPES survey response, SoonerStart logic model, <http://se.sde.state.ok.us/ses/preschool/publications/SoonerStart%20Logic%20Model%20525.pdf>, and 2004 data report of the Arthritis Education and Prevention Program, <http://www.health.state.ok.us/program/apep/arthWebFinal.pdf>.*

States can facilitate efforts to develop and advance effective health information systems that rely on health information exchange and technology by convening key stakeholders and by revising and developing state laws and regulations. Even when states do not play a major role in financing health information exchange and technology, they can support demonstration initiatives, encourage or require use of health information exchange and technology as purchasers, and account for health IT-related costs in their payment policies. As a provider of health services, states can build electronic health information connections among state health care facilities and can incorporate electronic health tools into facilities' daily operations, while also addressing potential public health responsibilities, such as bio-surveillance or automated monitoring of disease outbreaks.

As of July 2006, 10 governors had issued executive orders addressing health IT and 22 legislatures had passed health IT-related legislation.<sup>20</sup> A 2006 study of community and regional initiatives conducted for the Agency for Healthcare Research and Quality identified 165 health IT initiatives in 49 states and two territories. Further, this survey found that 38 states were involved in either a local or statewide health IT initiative and 21 states were leading efforts to convene stakeholders.<sup>21</sup> This survey also showed a significant increase in state activity related to health IT initiatives within the past year.

The SHAPES survey asked about roles states are playing in health information exchange or technology initiatives. Results showed that most states are playing a number of roles. Over half of responding states were reviewing and revising legislation or regulations to facilitate health information exchange or technology. Twenty of 33 responding states were participating in private sector-led efforts, such as Regional Health Information Organizations. Many states were providing financial support including funding demonstrations and hiring consultants to develop system development plans. Only three states reported providing purchasing incentives for health information exchange or technology.

### ***Building Electronic Infrastructure in Connecticut***

Connecticut has begun an effort to develop a range of electronic infrastructure tools that will be shared across health care providers to speed the delivery of necessary health care services. The nonprofit eHealth Connecticut project was launched in 2006, and has plans to develop the following tools:

- Health Information Exchange and e-Prescribing with the Connecticut State Department of Social Services, including a master database of diagnoses, medications, allergies, and adverse drug events for all state Medicaid recipients
- Aggregating quality measures at the individual provider level, to allow for enhanced public reporting and the development of pay-for-performance
- Data-sharing among hospital emergency departments, including the development of a master person index to merge records for a single individual from multiple different sources
- Emergency preparedness, to develop secure electronic health records for all state residents in the event of a statewide emergency or health crisis.

State officials sit on the eHealth Connecticut board to give input and guidance to the public-private partnership. The program held its first summit in March 2006, which introduced participants to ideas about health IT and identified potential challenges, such as privacy concerns and the need for buy-in among community health care providers. A follow-up meeting provided a forum to share the lessons and challenges of planning and implementing projects throughout Connecticut.

Sources: Connecticut Governor's Office SHAPES survey response, and eHealth Connecticut Web site, <http://www.ehealthconnecticut.org/>.

Twenty of 33 responding states reported they were convening stakeholders and agencies to address health information exchange and technology. States most frequently cited communication, coordination, and information as the focus of such meetings, but some reported focusing on defining the business case for various sectors; identifying and resolving barriers that impede diffusion of telehealth; developing and refining policy

recommendations; and developing multiyear implementation plans. States were most commonly engaging hospitals, health plans, providers, academic medical centers, and consumers in these efforts, although a range of other stakeholders were identified across states. The majority of state Medicaid agencies were actively involved in these health information exchange and technology initiatives. Many were looking to a new federal grant funding initiative to transform systems for help in supporting these efforts.

### **Integrating Health Care and Population-Based Public Health Systems**

Population-based strategies are necessary to support prevention and promotion of long and healthy lives. Individual behaviors and environmental factors are responsible for about 70 percent of all premature deaths in the United States. According to the U.S. Department of Health and Human Services' *Healthy People 2010*, the national blueprint for achieving improvements in health status, "developing and implementing policies and preventive interventions that effectively address these determinants of health can reduce the burden of illness, enhance quality of life, and increase longevity."<sup>22</sup>

Population-based approaches to achieving improved health outcomes require strong public sector roles and leadership. In *The Future of Public Health*, the Institute of Medicine defined key public health roles to include assessment, policy development, and assurance. Federal public health agencies later worked with state and other partners to articulate essential public health services. These core functions and essential services continue to guide efforts at federal, state, and local levels to achieve health improvements with population-based approaches.<sup>23</sup>

We found that most states—26 of 33 that responded to this question—have major initiatives under way to better integrate public health and health care policies and systems to achieve improved outcomes. In response to the survey choices, states reported most frequently focusing on tobacco use, obesity, immunizations, birth outcomes, screening, and substance abuse. Other issues (reported by more than one state) included diabetes, asthma, injuries, and dental health. Health disparities, rural health, cancer, HIV/AIDS, emergency preparedness, mental health, health literacy, and e-health were also noted.

States reported that public health and Medicaid agencies were most frequently engaged in these initiatives, and state employee health plans and SCHIP programs were involved in a fewer—but still substantial number—of states. Other state agencies involved in such initiatives were mental health, education, and agencies addressing health care reform, managed health care, and statewide health planning.

### ***Incentives for Wellness in Arkansas***

Arkansas provides health care benefits through plans offered to state and public school employees and their families, covering approximately 120,000 people. In this role, the state has a financial interest in improving the health status of this population. In 2004, it began a long-term strategy to avoid preventable diseases and encourage healthy behaviors. It introduced Health Risk Assessments (HRA) to gauge member behaviors in five areas: smoking, alcohol consumption, seat belt usage, body mass index, and weekly physical activity.

The state's strategy relies heavily on incentives for positive behaviors. Members who complete an HRA receive a \$10 monthly discount to their health insurance premium; those who are found to be at low risk receive an additional \$10 discount. In 2005, more than half of members completed the HRA. Arkansas has introduced enhanced tobacco cessation and obesity management (including nutrition counseling) benefits, and has proposed a further expansion of coverage for clinically directed weight-loss programs and surgical obesity interventions. State employees who assist in management of their health risks are also eligible for three days of vacation, known as "health days."

This is complementary to the state's effort, through the Healthy Arkansas initiative, to advance the idea of "worksite wellness." This effort promotes the notion that because adults spend most of their waking lives at work, work environments should promote healthy choices and healthy behaviors.

Sources: Arkansas Governor's Office SHAPES survey response, presentation by Rhonda Jaster, [https://arbenefits.org/ebd\\_pages/forms/presentationEBDStateHRABackground.pdf](https://arbenefits.org/ebd_pages/forms/presentationEBDStateHRABackground.pdf), presentation by Joseph Thompson, <http://www.nga.org/Files/pdf/0512HEALTHYThompsonJoe.PDF>, and Healthy Arkansas Web site, [http://www.arkansas.gov/ha/worksite\\_wellness/index.html](http://www.arkansas.gov/ha/worksite_wellness/index.html).

## **CONCLUSION**

**States' multiple roles in the health care system create myriad opportunities for promoting health system performance and many states avail themselves of these opportunities.** The survey found examples of state action in every domain of health system performance. States are working to promote equal access to health insurance coverage by exceeding federal minimums in public health insurance programs, funding their own programs, and regulating the insurance marketplace. They are addressing the content of coverage to help people obtain the benefits they need, defining minimum benefit packages, and requiring public or private coverage to address pressing unmet needs in areas like dental care and mental health services. States have become active in promoting quality, public reporting, creating purchasing specifications, and convening public and private entities that have roles in systems improvements. States continue to work to ensure that providers are available, especially for traditionally underserved populations, and to join public health strategies with health care strategies to improve outcomes. States are integrating data systems and working with the private sector to facilitate the technology and systems needed for effective information exchange to improve efficiency.

**Every state reported activity to promote achievement of a high performance health system.** While this finding was not unexpected, the study underscores the fact that states are important players with multiple roles in achieving improved health system performance. Fifty-one jurisdictions each shared information about actions in one or more of the domains of access, quality, and infrastructure.

**States play an important role in securing insurance coverage and access to health care services for vulnerable populations.** All states are playing a role in promoting more equal access to the health care system. More than four of five states cover children at income levels that meet or exceed the minimums under federal programs. Some states are blazing trails in promising coverage for all children. In addition, some states are moving to ensure that everyone, adults included, has affordable coverage. States also are simplifying administrative processes and beginning to make greater use of technology for application, enrollment, renewal, and coordination of coverage, as well as for other services. Most states fund scholarships or loan repayment programs to make sure providers are available for underserved populations, and many are monitoring the health care safety net to develop policies and plans to protect and strengthen it.

**States are moving beyond historic roles to exert influence with the private insurance market, leverage their purchasing power, and collaborate more with the private sector.** States are becoming more active in areas that are historically the province of the private sector or the federal government. Some of the more noteworthy findings concern the role of states in the private insurance marketplace. For instance, more than half of the responding states reported they require minimum benefit packages for the individual or small-group market. Most states have programs to reduce the cost of coverage for small employers and their workers. Also, having moved over time from roles as payers for limited groups of vulnerable people to purchasers for a substantial share of the population, states are taking advantage of the opportunities to influence the content and quality of care. Most consider quality when making contracting decisions and require reporting on quality measures. States are maintaining their focus on the needs of racially and ethnically diverse populations, as well as vulnerable populations, such as children and those with disabilities, increasingly through contractual obligations. In addition to serving as regulators and purchasers in the private sector, states also are partnering and collaborating in areas relevant to system performance. Many states play active roles in public-private or privately led quality forums or health information organizations.

**Fewer states are actively pursuing system performance in areas such as efficiency and patient safety.** Improving the quality of health care services has become a major

focus for many states. However, efforts focused specifically on the safety of care were less frequently reported. The survey did not query extensively about efficiency, but a few states volunteered information in this area. These findings may reflect the lack of a clear federal framework for action, the recent emergence of these issues relative to topics like insurance coverage, or a belief that federal action will supersede the role of states.

**In every area there is room for states to do more in pursuit of high health system performance.** While the level of state activity in many areas is impressive, there clearly is room for growth and improvement. Although there are very real fiscal constraints regarding coverage in the absence of strong federal action, many states could work to bring coverage levels to the level of their peers in other states by increasing federally matched public program eligibility levels and by simplifying and automating enrollment and renewal processes. More states could use regulatory levers to influence the private marketplace to provide affordable products with adequate benefit packages. Many states and agencies could increase their attention to contract quality provisions, especially those addressing the specific needs of children, diverse racial and ethnic groups, and individuals with special health care needs. State employee health plans generally lagged behind Medicaid and SCHIP agencies in using purchasing levers to affect content and quality of care. More states could monitor and address the strength of the health care safety net; this is another area where federal leadership and support is important. By collaborating with the private sector to facilitate health information exchange and equality, states could support more rapid adoption of systems that improve quality and efficiency of care.

**Ongoing mechanisms to monitor, study, and report state activities could help diffuse and speed adoption of promising policies and practices.** Some of the policies and practices reported by states, particularly those related to public coverage, are monitored and reported on a regular basis by national organizations, including NASHP. However, many are not. As states look to other states for advice and ideas, it is important to have a source of current information on activities and outcomes to facilitate learning and adoption of proven and promising policies and practices. Such a bank of information would assist federal agencies, foundations, researchers, and others interested in guiding, assisting, and evaluating state efforts. This survey laid important groundwork in identifying relevant state policies and practices. In the future, a mechanism that obtains similar, updated information from surveillance of state activity could help states move toward better performance.

**More in-depth exploration of specific areas of state activity could yield richer information that would aid states in their efforts to improve system performance.**

The SHAPES survey only brushed the surface of a broad range of state policies and practices. More in-depth exploration would yield additional information that might prove useful to understanding impact and to accelerating diffusion. Areas that appeared particularly noteworthy include: assisting small employers with affordable coverage; developing minimum benefit packages for the private market or public programs; developing and maintaining interagency and public–private quality collaboratives and forums; using purchasing levers to address patient safety; revising policies and providing incentives for health information exchange and technology; and integrating population-based and health care system strategies to achieve improved health outcomes.

**Opportunities for states to exchange information on their efforts to improve health system performance could help transfer knowledge and experience and could spark new and innovative approaches.** National efforts to support state-to-state learning exist, but tend to be focused in a few specific areas, such as coverage. NASHP’s experience has demonstrated over and over again that states highly value and actively apply ideas learned from or sparked by exchange with their peers who are grappling with similar health system issues, opportunities, and barriers. Opportunities for states to share ideas, lessons learned, and operational details could help states improve and, ultimately, move the nation toward a high performance health system.



## NOTES

<sup>1</sup> The Commonwealth Fund Commission on a High Performance Health System, [\*Framework for a High Performance Health System for the United States\*](#) (New York: The Commonwealth Fund, Aug. 2006).

<sup>2</sup> C. DeNavas-Walt, B. D. Proctor, and J. Smith, “Income, Poverty, and Health Insurance Coverage in the United States: 2006,” U.S. Census Bureau, Accessed Nov. 29 2007. [http://www.census.gov/hhes/www/hlthins/hlthin06/p60no233\\_table6.pdf](http://www.census.gov/hhes/www/hlthins/hlthin06/p60no233_table6.pdf).

<sup>3</sup> Congressional Budget Office, *The State Children’s Health Insurance Program* (Washington, D.C.: CBO, May 2007).

<sup>4</sup> U. Ukaegbu and S. Schwartz, *Seven Steps Toward State Success in Covering Children Continuously* (Portland, Maine: National Academy for State Health Policy, Oct. 2006).

<sup>5</sup> L. Chimento, A. Theisen-Olson, and M. Bhat, *Electronic Applications Present Opportunities to Improve Enrollment into New York’s Public Health Insurance Programs* (Falls Church, Va.: The Lewin Group, Nov. 2004).

<sup>6</sup> “The Oral-Systemic Disease Connection,” *Journal of the American Dental Association* 137 special supplement (Oct. 1, 2006):5S–36S. Note that this supplement includes an article linking periodontal disease to preterm birth; the research supporting the “preterm-perio” link is less settled than other oral-systemic links. See for example A. Brown and B. Zimmerman, *Research to Policy and Practice Forum: Periodontal Health and Birth Outcomes—Summary of a Meeting of Maternal, Child, and Oral Health Experts* (Washington, D.C.: National Maternal and Child Oral Health Resource Center, 2007).

<sup>7</sup> California, Connecticut, New Jersey, New York, North Dakota, Pennsylvania, Wisconsin.

<sup>8</sup> Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Minnesota, Montana, Nebraska, New Mexico, North Carolina, Ohio, Oregon, Rhode Island, South Dakota, Utah, Vermont, Washington.

<sup>9</sup> Medicaid/SCHIP Dental Association, [\*Adult Dental Benefits in Medicaid: FY 2000, 2002, 2003, 2004 & 2005\*](#). States include Alaska, Arizona, Florida, Georgia, Hawaii, Idaho, Maine, Maryland, Massachusetts, Michigan, Mississippi, Nevada, New Hampshire, Oklahoma, South Carolina, Tennessee, West Virginia, Wyoming.

<sup>10</sup> Mental Health America, [\*What Have States Done to Ensure Insurance Parity?\*](#) (Alexandria, Va.: Jan. 2007).

<sup>11</sup> H. E. Varmus, [\*Parity in Financing Mental Health Services: Managed Care Effects on Cost, Access and Quality\*](#) (Washington, D.C.: National Institute of Health, May 1998).

<sup>12</sup> J. Rosenthal and M. Booth, [\*State Patient Safety Centers: A New Approach to Promote Patient Safety\*](#) (Portland, Maine: National Academy for State Health Policy, Oct. 2004).

<sup>13</sup> The Commonwealth Fund Commission on a High Performance Health System, [\*Why Not the Best? Results from a National Scorecard on U.S. Health System Performance\*](#) (New York: The Commonwealth Fund, Sept. 2006).

<sup>14</sup> The Medicaid survey referred to the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) pediatric standard of medical necessity. EPSDT provides comprehensive health services for infants, children, and adolescents enrolled in Medicaid.

<sup>15</sup> F. P. Glascoe, “Early Detection of Developmental and Behavioral Problems,” *Pediatrics in Review*, Aug. 2000 21(8):272–80.

<sup>16</sup> Arizona, Indiana, Louisiana, Massachusetts, Minnesota, Missouri, Nevada, New Jersey, Oklahoma, Tennessee, Texas, Utah.

<sup>17</sup> M. Ein Lewin and S. Altman (eds.), [\*America's Health Care Safety Net: Intact but Endangered\*](#) (Washington, D.C.: National Academies Press, 2000).

<sup>18</sup> Association of State and Territorial Health Officials, *Access Brief: TeleHealth* (Arlington, Va.: Aug. 1999).

<sup>19</sup> Commonwealth Fund Commission, *Why Not the Best?*, 2006.

<sup>20</sup> eHealth Initiative, [\*States Getting Connected: Quality and Safety Driving Health IT Planning in a Majority of States in the United States\*](#) (Washington, D.C.: July 2006).

<sup>21</sup> eHealth Initiative, [\*Improving the Quality of Healthcare Through Health Information Exchange\*](#) (Washington, D.C.: Sept. 2006).

<sup>22</sup> Office of Disease Prevention and Health Promotion, [\*A Systematic Approach to Health Improvement\*](#) (Washington, D.C.: Nov. 2000).

<sup>23</sup> Institute of Medicine, Committee for the Study of the Future of Public Health; Division of Health Care Services, [\*The Future of Public Health\*](#) (Washington, D.C.: National Academies Press, 1988).

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