

State Health Policies Aimed at
Promoting Excellent Systems:
A Report on States' Roles in
Health Systems Performance

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- Conduct policy analyses and research.
- Disseminate information on state policies and programs.
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- Identifying and describing emerging and promising practices.
- Developing leadership capacity within states by enabling communication within and across states.

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EXECUTIVE SUMMARY

States shape the health system in many ways: as purchasers, regulators, and conveners. Despite these various roles, there is little systematic effort to monitor state choices, learn from the choices states make, and purposefully spread one state's innovations to other states. Coordination between states and the federal government on approaches to improving the health care system is often lacking, limiting our nation's ability to address critical problems.

In an effort to improve health system performance and increase the spread of innovation, the National Academy for State Health Policy (NASHP), with support from the Commonwealth Fund, prepared this report on a broad array of state health policies and practices. This report describes a tremendous amount of activity at the state level and which has implications for how well the health care system performs.

States are engaged in system improvements across the full spectrum of their authority. States are purchasing care, regulating providers, and gathering and analyzing data with an eye toward health system improvement. States are participating in and sometimes leading public/private efforts to improve the health care system. And states are undertaking a variety of efforts to expand the availability and affordability of health insurance. These actions are valuable in their own right. Yet, if the nation were to make a concerted effort to design, monitor, evaluate, refine, and replicate successful practices, state action could serve as an even stronger force for health system improvement in the United States.

This report builds upon the work of the Commonwealth Fund's Commission on a High Performance Health System. The report organizes the attributes of high performance defined by the Commission into groupings relevant to state health policy and practice.

- States can work toward the goal of equitable and affordable coverage of essential health care services for everyone. Policies and practices regarding public program eligibility, enrollment, retention, and benefit design can support this goal as can state policies regarding private insurance affordability, availability, and benefit design.
- States can strive to ensure everyone receives the right care at reasonable cost, and receives equitable care that is safe, patient-centered, and coordinated. State purchasing policies and practices that provide incentives for high performance can help achieve these aims. State leadership of or participation in public/private collaborations in data collection, analysis, and public reporting of quality and patient safety indicators also can support these goals.
- States can support development of health systems infrastructure that provides to everyone access to systems of personal health and population-based public health services that promote long and healthy lives, and that has the capacity to improve. State policies and practices that bring together personal health care and public health systems can work on common goals, such as addressing provider availability and access to care, especially for vulnerable populations. State support for information systems and health information technology can also help develop these critical infrastructure components for the health system.

Themes and Noteworthy Findings

This study revealed a great deal of variation across the country, yet at the same time uncovered important state achievements that show the way for additional action and attention. The following were identified as important or growing areas for state action:

Coverage

- *Ensuring affordable health coverage is a major role for states, not only in maximizing use of federal programs, but going beyond them with state-only investments and public-private approaches.*
- *States are making use of technology in their efforts to streamline public coverage enrollment and renewal, but there is significant potential for them to do more in this area.*
- *States 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.*

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 publicly reporting data that can help assess health system performance, although with more focus on quality than safety and more reporting from hospitals than other providers.*
- *States are using a variety of levers to purchase for quality, including requiring reporting on quality, employing specific contractual provisions for vulnerable populations, and having joint quality requirements in multiple agency purchasing.*

Health systems infrastructure

- *States are playing significant roles, in partnership with the private sector, to build information systems necessary for health system improvements.*
- *States are working to integrate health care and population based public health systems in order to achieve improved health outcomes.*
- *States are addressing health system provider capacity by monitoring the safety net, addressing provider shortages, and reimbursing for telehealth.*

Health system performance within states is the result of many factors – state policies are relevant but certainly not the only factor in achieving results. This report is intended to recognize state achievements and highlight the potential of states to learn further from each other to exert even greater influence on health system performance. The *State Scorecard on Health System Performance*, released in 2007 by the Commission on a High Performance Health System, documented great variation across states in access, quality, avoidable costs, equity, and achieving

healthy lives. It also demonstrated the interrelated nature of these topics – particularly that states with poorer access also showed poorer quality – and the importance of pursuing all aspects of high performance simultaneously. Together, this report and the *State Scorecard* can help point the way for further progress and inquiry into the effects of specific state policies.

The information presented in this report comes from a unique and ambitious undertaking. The data collection strategy for *State Health Policies Aimed at Promoting Excellent Systems* (SHAPES) was 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 sources of data on state policies were unavailable.

Reflecting the fact that multiple state agencies are involved in setting health policy, up to six separate executive branch agencies in each of the 50 states and the District of Columbia were identified as potential sources of data. In late September 2006, 291 surveys were sent to Medicaid, insurance, SCHIP, public health, state employee benefits, and governor’s health policy offices. Follow-up was targeted at Medicaid, SCHIP, and state employee benefits, since they tend to have the greatest involvement in the policies and practices covered by this report. Ultimately, all 51 jurisdictions responded, with an overall agency response rate of 52 percent.

The breadth of the SHAPES survey, the variability in agency responses, and the response rate all suggest caution in interpreting its results. Despite the survey limitations, we feel comfortable identifying key themes, findings, and conclusions drawn from the survey responses as well as from other sources of data that we identified.

Conclusion

Our review of existing data on state activities relevant to system performance, combined with the new information we gathered from the SHAPES survey, led us to the following conclusions.

- States’ multiple roles in the health care system create myriad opportunities for promoting health system performance and many states avail themselves of these opportunities.
- States’ long-standing role in securing insurance coverage and access to health care services for vulnerable populations remains a focus of state activity in pursuit of better system performance.
- 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.
- Fewer states are actively pursuing system performance in areas such as efficiency and patient safety.
- In every area we examined there is room for states to do more in pursuit of high performance health system.
- Ongoing mechanisms to monitor, study, and report state activities could help spread and speed adoption of promising and best state health system policies and practices.

- More in-depth exploration of specific areas of state activity could yield richer information that would aid states and the Commission on a High Performance Health System in their efforts to improve system performance.
- Opportunities for state-to-state exchange about efforts to improve health system performance also could help spur transfer of knowledge and experience about what works and spark new and innovative approaches through joint state problem solving.

This full report provides more detail on state roles across the country, as well as illustrative state examples. A briefer summary report published by The Commonwealth Fund - *States' Roles In Shaping High Performance Health Systems* - includes themes, conclusions and selected state examples, and is available at www.commonwealthfund.org, as well as at www.nashp.org.

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INTRODUCTION

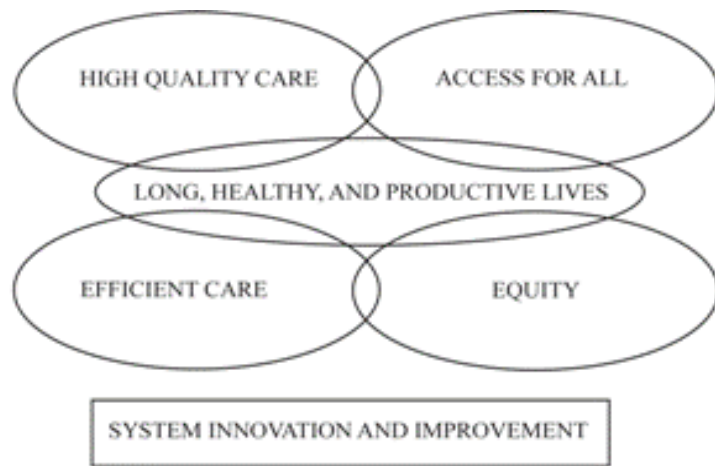
Background

In 2005, the Commission on a High Performance Health System was established by the Commonwealth Fund to “move the U.S. toward a health care system that achieves better access, improved quality, and greater efficiency, particularly for those who are most vulnerable.” As this effort began, the Commission and the Fund recognized that states have a vital role to play in achieving the vision of a high performance health system. In response, the National Academy for State Health Policy (NASHP), a state-based forum and resource for policy analysis and assistance, took on the challenge of identifying and describing the kinds of roles, policies, and practices that states are implementing and which can contribute to health system transformation.

This exploratory examination of state policy and practice across agency and program lines and across broad domains, including access and quality, is unique in its broad scope. Designed at the same time as the Commission was developing the vision and values to guide its work, the study of State Health Policies Aimed at Promoting Excellent Systems (SHAPES) began by considering the types of state health policies and practices that show evidence or offer strong promise for improving health systems. A scan of related policy literature and consultation with a subgroup of Commission members led to development and later distilling of a list of possible policies and practices that met criteria developed by the project. Chief among these criteria, which are listed in full in the methodology appendix to this report, was that the policies and practices reflect governmental action and that they are actionable by states. The study and this report are intended to support and stimulate further state policy actions that collectively move the U. S. health system closer to the levels of performance achieved in many other nations.

The vision developed by the Commission guided this project’s development of a framework for selecting and reporting on such state policy and practices. As depicted below, a high performance health system is one that provides access for all to high quality, efficient, and equitable care, contributing to long, healthy, and productive lives. Innovation and improvement in health systems supports achievement of these key outcomes. States can and do provide leadership and work toward achieving these outcomes and improving health systems in a variety of ways, from financing, to legislating and regulating, to studying and reporting, to collaborating with the private sector. This report describes some important and some innovative ways in which states are acting to achieve the outcomes of high performance health systems.

Figure 1 High Performance Health System¹



Methods, organization, and content of the study and report

Consistent with the Commission’s vision and with state roles relevant to achieving the vision, NASHP developed a framework that guided the selection of policies and practices we examined. The study and this report are organized around this framework:

- Coverage of essential benefits, consistent with a goal that everyone has equitable and affordable coverage of essential health care services. This set of state policies and practices addresses such elements as health insurance eligibility and affordability, enrollment and retention, and benefits.
- Quality, efficiency, and value, consistent with a goal that everyone receives the right care at reasonable cost, and receives equitable care that is safe, patient-centered, and coordinated. These state policies and practices include such elements as purchasing for value, performance incentives and disincentives, public reporting of quality and patient safety indicators, and collaboratives and other cross-sector strategies for pursuing quality improvements.
- Health systems infrastructure, consistent with a goal that everyone have access to systems of personal health care and population-based public health services that promote long and healthy lives, with such infrastructure having the capacity to improve. These state policies and practices include such elements as joint health care and public health initiatives, information systems and technology, and provider availability and access, especially for vulnerable populations.

A more detailed description of the design and methods used for this study and report is included in the appendix. In brief, the framework described above was utilized to generate a list of potential state policies and practices for study. An advisory group comprised primarily of Commission members consulted with NASHP in narrowing the potential list. We reviewed the potential list against a number of key project criteria: the relative importance of the policy; its variability across states; and the degree of consensus on the evidence or potential for the policy

to improve some aspect of system performance. NASHP also scanned literature, including grey literature produced by various organizations, to identify recent reports addressing state health policy and practices in all states in areas of interest. Reports were reviewed to ascertain whether they provided the information needed to describe the areas of interest in this study. Based on the advisory group input and the literature scan, NASHP selected a limited although still quite extensive set of policies and practices to address in the report, drawing from the existing survey literature when possible. For policy or practice elements not readily available from recent survey literature, NASHP surveyed states to obtain information.

Given that this study was seeking information on state policies and practices regardless of agency, and that states vary considerably in their structures and in which agencies carry out which roles, NASHP determined it would need to survey at least six executive branch agencies or offices in seeking the information of interest. These agencies included:

- Medicaid,
- Insurance,
- SCHIP,
- Public Health,
- State Employee Health Plans, and
- Governor's health policy offices.

Survey questionnaires that included some common and some agency specific questions were developed. In late September 2006, 291 surveys were sent to these agencies and offices in all states and the District of Columbia. As of January 2007, the cut-off date, NASHP received responses from at least one agency in all 51 jurisdictions. Within the timeframe available, NASHP also achieved an overall individual agency response rate of 52 percent, with higher rates from agencies targeted in follow-up and which were viewed as being most likely to be carrying out policies and practices of interest.

This report draws on selected responses to these surveys as well as other recent survey studies to describe state policies and practices that together hold potential for transforming the U.S. health system. These survey highlights are supplemented by state examples culled from the surveys and other sources. The study and report are exploratory and not exhaustive. The report is intended as a starting guide for states and other interested stakeholders on ways in which states can help the U.S. achieve the kinds of successes already achieved in other nations. The aim is for the report to help move us closer to a high performance health system both by helping states learn from each other and by informing the national debate about health policy with lessons learned from the states.

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COVERAGE

Introduction

The Commission on a High Performance Health System has recognized that equitable and affordable coverage of essential health care services for everyone is a critical factor for transforming our health system.

When some members of our society are uninsured or underinsured, additional costs can be generated for the whole system.

- First, individuals who have health insurance pay more to cover the cost of the uninsured. A recent study showed that the average California family paid an additional \$1,186 in health insurance premiums in 2006 because there is a hidden tax on behalf of those who cannot pay.¹ And, when the uninsured rely on emergency rather than preventive care, costs are added for everyone.²
- Second, uninsured Americans forgo or delay critical health care because they lack health insurance coverage.³ More than one-fourth of uninsured adults with chronic conditions reported no visits to a health professional in 2003, and nearly half went without medical care or prescription drugs due to cost.⁴ Uninsured patients are likely to be in poorer health than insured patients,⁵ and are three times more likely to die in the hospital than insured patients.⁶ A study of previously uninsured, low-income children before and one year after enrollment in public programs in one state showed a dramatic decrease among these newly insured children who delayed or did not get needed prescription drugs, medical, dental, and vision care.⁷

Recent 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 their residents. While not every state is working on an ambitious plan to cover all of the uninsured, all states are playing a significant role in working toward this goal. States can ensure that coverage is affordable by expanding public coverage, including Medicaid and the State Children's Health Insurance Program (SCHIP), above and beyond federal requirements; creating public-private partnerships; and regulating and monitoring the private health insurance marketplace. States also can create systems to keep people more continuously covered by improving outreach, enrollment, and retention in coverage. Finally, states can take action to assure that people receive necessary benefits.

The SHAPES study focused on key state policies and practices related to health coverage that were identified by NASHP and the project advisory group. While it draws heavily from the study's surveys, this section of the report in particular incorporates some of the extensive existing information on state coverage that is available from other sources.

Providing Affordable Health Coverage

This section examines how states provide affordable coverage through public programs, how they use public-private partnerships to encourage coverage, how they employ market regulation to promote access, and how their data collection and information sharing supports policy making. These are all key elements in reaching the Commission's goal of universality.

Many states have gone beyond federal minimum requirements in Medicaid and SCHIP in providing coverage for those in need

States play a key role in designing and financing health coverage for their residents. Most coverage organized by states is provided through Medicaid or the State Children's Health Insurance Program (SCHIP), but states have created other programs to fill in gaps and provide coverage.

Medicaid and SCHIP are state-federal partnership programs that cover more than 45 million people nationwide.⁸ Both programs allow states to draw down federal funds to cover certain people who meet income, asset, and other eligibility criteria. Under Medicaid, federal law

Affordable and simpler coverage for everyone: Massachusetts

A key component of Massachusetts' recent health reform – which includes an individual mandate to buy health insurance – is providing affordable coverage. Uninsured Massachusetts residents (citizens and legal immigrants) falling below 300 percent of the poverty level now qualify for some type of subsidized insurance. They can enroll in coverage either through MassHealth (Medicaid and SCHIP) or Commonwealth Care, a tiered insurance product with benefits and cost-sharing requirements that vary by income, delivered by the same managed care organizations as MassHealth. In order to simplify enrollment, the programs all use a single application, and the MassHealth agency reviews all applications to determine which program the applicant qualifies for. Medicaid, SCHIP, or other state funding then finance coverage for each enrollee.

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 entire families and adults living on their own to more easily identify themselves as eligible and enroll in coverage.

The financing 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 received previously to support safety net hospitals. The waiver agreement that was reached allows 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 are being offered through the state's new Commonwealth Care agency, or through employers.

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

Medicaid and SCHIP are state-federal partnership programs that cover more than 45 million people nationwide.⁹ Both programs allow states to draw down federal funds to cover certain people who meet income, asset, and other eligibility criteria. Under Medicaid, federal law requires states to provide health coverage for certain categories of people, such as children, pregnant women, parents, the elderly, and people with disabilities, but states can and often do go beyond these minimums to draw down federal funds to provide coverage for additional people.¹⁰ States cannot use Medicaid funding for certain additional populations – like non-disabled adults without children – without obtaining a waiver from the federal government.

Medicaid is an individual entitlement program, which means that eligible individuals are entitled to coverage, and funding is open-ended to assure this. SCHIP is a program with guaranteed but capped funding for states. To stay within SCHIP budgets, states have options such as closing enrollment. SCHIP can be implemented through an expansion of Medicaid, through a separate SCHIP program, or a combination of the two.

As explained below, Medicaid and SCHIP rules have created unique opportunities and challenges for states in providing coverage to children, pregnant women, parents, and legal immigrants.

Most states provide coverage for children in families with incomes at 200 percent of poverty or higher

Under federal law, states wishing to receive Medicaid funding must, at a minimum, provide Medicaid coverage to certain categories of children. Some of these categories include children under age 6 in families with income at or below 133 percent of the federal poverty limit, and children under age 19 with family income at or below 100 percent of the federal poverty limit. Under SCHIP rules, states provide coverage to certain children with incomes not exceeding 200 percent of the federal poverty level (FPL) or no more than 50 percent over the state's Medicaid income eligibility as of June 1, 1997, whichever is higher.

However, many states go beyond the Medicaid requirements and are at the outer limits of what SCHIP allows. As of July 2006, 41 states covered children in families with income 200 percent of FPL or higher with Medicaid or SCHIP.¹¹ Other states have efforts underway to cover all children and subsidize children at higher income levels with state funds.

Nearly half of states are working on efforts to cover all children

Many states have been active recently in efforts to cover all children. More than half of states that responded to this part of our survey (25 out of 47)¹² reported an executive-branch agency plan or initiative underway to cover all children. These efforts range from helping a governor prepare a plan for covering all kids; developing expansions or federal waiver initiatives for Medicaid or SCHIP; developing more discrete models and approaches for covering more kids; and working on outreach, enrollment, and retention for children who are eligible for programs but not enrolled.¹³

Covering All Kids: Illinois

Illinois is making health coverage available to all uninsured children through its All Kids program. All Kids is built on the foundation of Illinois' Medicaid and KidCare (SCHIP) programs, and it offers a very similar benefit package. From the program's inception on July 1, 2006 through December 15, 2006, approximately 100,000 new children were reached by All Kids. About two-thirds of these children had low enough incomes to be eligible for the Medicaid or SCHIP segment of the program; thus, federal matching funds were available for these children. The remaining children were enrolled in the All Kids expansion, which is funded solely by state funds.

Children of any family income and any immigration status who have been uninsured for 12 months, or whose family has involuntarily lost insurance coverage, may enroll in the All Kids expansion. The expansion is divided into seven tiers, with premiums and cost-sharing requirements that slide upward as income increases. At the lower end of the scale (200 to 300 percent of the federal poverty level), the state subsidizes the premium, and families contribute \$40 per child per month; in the highest tier, the family pays the entire premium of \$300 per child per month. Illinois estimates that the total cost of the program to the state will be \$45 million in the first year, with some costs offset by increasing the use of primary care case management and disease management across the state's covered populations.

Illinois is engaging in vigorous outreach efforts for the expansion, including designation of community organizations, unions, local governments, medical providers, and insurance agents as All Kids Application Agents. These entities are trained by the state to assist families in applying for All Kids benefits. In exchange, they receive a \$50 payment for every completed application that results in an enrollment.

Sources: Presentation by Dr. Steven Saunders to State Coverage Initiatives National Workshop, <http://www.statecoverage.net/0107/saunders.pdf> <http://www.allkidscovered.com/>, and the All Kids website, <http://www.allkids.com/>.

The majority of states provide coverage for pregnant women at 185 percent of poverty or higher

Under federal Medicaid law, states must cover pregnant women up to 133 percent of the poverty level and states can receive federal matching funds for coverage of pregnant women with incomes up to and beyond 185 percent of FPL.¹⁴ As of July 2006, 37 states go beyond these minimums and cover pregnant women at 185 percent FPL or higher.¹⁵

Less than half of states provide coverage to parents or to other adults with poverty-level and above incomes

Under federal Medicaid law, states must cover certain parents with very low incomes and have the option to provide coverage to additional parents.¹⁶ Sixteen states cover parents in families with income at 100 percent of the FPL or higher with Medicaid or SCHIP.¹⁷

Medicaid generally does not provide funding for states to provide coverage to healthy, working adults without children. States must obtain a waiver from the federal government in order to cover this population. Less than half of states (17)¹⁸ have received waivers to use Medicaid

funding to cover childless adults.¹⁹ At least two states are using state funding, with no support from Medicaid, to cover childless adults (Washington, Pennsylvania).²⁰ Some states also subsidize coverage for childless adults through programs aimed at expanding coverage for small employers (see below).

Many states provide coverage for legal immigrants with state funding

Before 1996, legal immigrants who met income, asset, and other eligibility requirements were treated like citizens for the purposes of Medicaid eligibility. Welfare reform in 1996 changed this policy and linked eligibility to legal status and length of residency in the U.S. Today, legal immigrants are subject to a five-year bar on eligibility for Medicaid and SCHIP and undocumented immigrants and immigrants in the U.S. on a temporary basis are ineligible for Medicaid and SCHIP.²¹ However, many states have identified the need to cover legal immigrants and have continued to provide health coverage to them either by using state funding to fill gaps in federal programs, or by subsidizing coverage for these groups in other state programs.

Nearly half of states that responded to this section (17 states out of 41)²² indicated that they fund some type of coverage for legal immigrants, whether the coverage is similar to Medicaid or is a separate and distinct state program. Ten states²³ responded that they provide Medicaid coverage to this population using state funds. Twelve states responded that legal immigrants are covered in programs separate from Medicaid with state funds.²⁴ Five states responded that they provide coverage for this group through both Medicaid and a state-funded program.

States have developed many different public-private partnership approaches to provide additional coverage options and pool resources

States also can play a role in providing coverage to their residents by developing different types of public-private partnerships. Such partnerships may provide mechanisms for organizing new coverage options and for pooling resources from multiple sources. This section of our report looks at buy-in programs, coverage for small employers, and efforts to leverage funds from employers, workers, existing public programs, and other sources.

Many states have developed buy-in programs to fill coverage gaps

One tool states use to expand coverage or fill coverage gaps is to allow individuals to buy into existing public programs like Medicaid, SCHIP, or state employee health plans. Some buy-in programs, like buy-ins for people with disabilities, have federal funding to help states subsidize the cost of coverage. Other buy-in programs serve as a purchasing vehicle and the state or individuals or both pick up the cost of coverage. While each of these buy-in programs is small on their own, in many cases they allow people to stay covered during transitions where they might otherwise become uninsured. For example, these programs can bridge the gap in Medicaid coverage when returning to work with a disabling condition or illness, aging out or earning out of SCHIP coverage, or leaving work that provides coverage and starting one's own business or working for a smaller employer that does not offer coverage. In each case, buy-in programs give individuals access to a larger pool of coverage.

Many states offer buy-ins for people with disabilities

States can improve access to coverage for people with disabilities when returning to work or working more hours by allowing them to pay a contribution to keep Medicaid coverage that they were entitled to when unable to work or to work many hours. These buy-in programs are part of a broader federal effort to improve employment outcomes among people with disabilities by ensuring they have access to health coverage. Thirty-two states have such buy-in programs.²⁵ They differ greatly in terms of premiums charged.²⁶ Although enrollment in these programs is generally small – as of March 31, 2005, total enrollment across the U.S. was less than 80,000, and most states had fewer than 1,000 enrolled – these programs have a narrow target population, and their enrollment is growing steadily.²⁷ Buy-in programs for people with disabilities have proven to be a mechanism for keeping people covered by Medicaid. About two-thirds of people enrolled in the buy-in programs were in another Medicaid eligibility group before they enrolled.

Some states have created buy-ins to state employee health plans

States already provide coverage to their own employees, and opening up what in some cases can be a very large pool of coverage to additional payers can be one way to provide coverage for the uninsured. The majority of state employee health plans that responded to our survey (12 out of 17)²⁸ reported that their plans are open to participation by individuals other than active or retired state employees. Six states responded that local governments, in particular, can buy in. Some states responded that they allow local school districts to buy in, and some states responded that they allow foster care parents to buy in. At least two other states that did not respond to this part of the survey also have state employee plan buy-ins. West Virginia allows small businesses²⁹ and Connecticut allows certain nonprofit employers to buy into the state employee plan.³⁰

Some states offer buy-ins to SCHIP

States can allow families with incomes in excess of SCHIP program eligibility limits to purchase insurance coverage for their children through their state's SCHIP program. As of 2005, seven states³¹ had created SCHIP buy-in programs. As of September 2005, these seven states reported covering a total of 44,416 in their buy-in programs.³² States also have reported that these programs cost them little to operate – in fact, all seven states use the same administrative structure for their buy-ins as they do for SCHIP, and often use the same vendor, same contract, and same state agency staff to provide the same functions for their buy-ins. Most states pass on the full cost of administering the program to the families that purchase coverage. States have found these programs are needed to fill a coverage gap for children. The buy-in can help children stay covered when family income increases and exceeds SCHIP limits and other affordable coverage is unavailable. In some states, the program also is available to older youth, ages 19 to 21. While enrollment in these programs is generally small, they do offer a vehicle for coverage for a population of children that would not otherwise be covered.

SCHIP buy-in programs: New York

Expanding coverage by allowing families with incomes too high to qualify to buy into public programs is a tool that a number of states have used for some time. New York has operated a buy-in program for children since before the enactment of SCHIP in 1997. In 2005 children in families with incomes over the SCHIP threshold (net income over 208 percent of FPL) could enroll in New York's SCHIP program if they paid the full monthly premium. Depending on the health plan in which the child was enrolled, the premium could range from \$97 to \$152 per child per month. As of September 2005, about 12,000 New York children received coverage through the SCHIP buy-in, representing about three percent of the state's SCHIP case load.

New York's buy-in program is somewhat less restrictive than those offered by some other states:

- Families of any income level can participate
- Participation is not conditioned on having previously been a regular SCHIP enrollee
- There is no maximum amount of time that a child could be enrolled

Other states operating buy-in programs have made different policy choices: to target their buy-in programs to families just above the SCHIP threshold; to serve as a temporary bridge from SCHIP coverage to private insurance; or, to offer buy-in to certain children above age 18 (New York's program ends on a child's 19th birthday).

Source: Cynthia Pernice and David Bergman, SCHIP buy-In Programs, NASHP issue Brief, available at http://www.nashp.org/Files/SCHIP_Buy-in_programs_2006.pdf http://165.176.249.159/downloads/studies_reports/2006-HD48_SCHIP.pdf

The majority of states have programs in place aimed at reducing the cost of coverage for small employers and their workers

Employees of small businesses and their families are much more likely to be uninsured than employees of larger companies.³³ For example, in 2003, half of the uninsured population worked for small firms with fewer than 25 workers, or were self-employed.³⁴ States have experimented with many approaches over the years to try to improve the affordability and availability of coverage provided by small employers, including using purchasing pools, reinsurance, and premium assistance programs.³⁵

- Purchasing pools are public efforts to allow small or large employers or individuals to pool to purchase health insurance. The aim of a purchasing pool is to achieve lower cost premiums by bringing small groups together to spread risk more evenly and to achieve the buying power of large groups. Purchasing pools can be state funded or not.
- Reinsurance can be used to reduce premiums by shifting some of the expenses for high-cost enrollees to a third party (such as the state, a reinsurance pool, or a reinsurance carrier). Reinsurance also may lower premiums by reducing the need for insurers to hold excess reserves and can serve as a vehicle for subsidies to make insurance affordable for small businesses and low-income workers.³⁶

- Premium assistance programs allow states to use Medicaid or SCHIP funds to pay a portion of the employer sponsored coverage premiums for people who are eligible for these public coverage programs.³⁷

Nearly three-quarters of the states that responded to this section of NASHP’s surveys (34 states out of 46) indicated that they have policies or programs in place that are aimed at reducing the cost of coverage for small employers and their workers. Twelve states reported that they use premium assistance, six states reported that they have reinsurance programs, four states reported that they have purchasing pools, and twenty-four states responded that they used 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. Some examples follow.

- Alaska allows employers and self-employed individuals to form associations for purposes of purchasing insurance.
- Kansas encourages employers to offer health coverage by enhancing an existing state income tax credit available to small employers that provide group health coverage. The state has added a new tax credit for small employers that contribute to an employee's health savings account. This tax credit is available to employers with 2 to 50 employees and which have not contributed to employees’ health insurance program or health savings account in the previous two years.

Figure 2 State policies to reduce costs for small employers

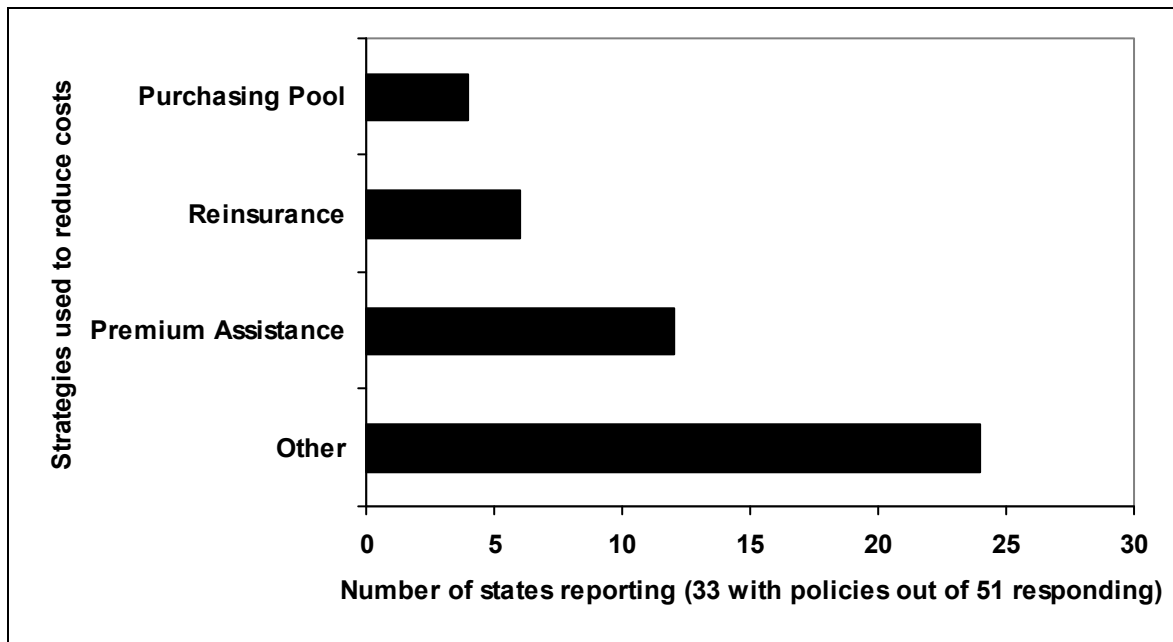


Table 1 State policies to reduce costs for small employers

State	Reinsurance	Purchasing pool	Premium assistance	Other
Alaska				•
Arizona				•
California				•
Colorado			•	•
District of Columbia			•	
Florida		•		•
Georgia				•
Idaho	•		•	
Iowa				•
Kansas			•	•
Kentucky			•	
Louisiana				•
Maine				•
Maryland				•
Massachusetts			•	
Michigan				•
Minnesota	•	•		•
Montana		•	•	
Nebraska	•			
Nevada				•
New Mexico				•
New Jersey		•	•	
New York				•
North Carolina				•
Oklahoma	•		•	
Oregon				•
South Carolina				•
Tennessee				•
Utah			•	•
Vermont	•		•	
Washington			•	•
West Virginia				•
Wisconsin				•
Wyoming	•			
Totals (n=34 of 46 states responding to this question)	6	4	12	24

- Maine offers the DirigoChoice plan, which was developed to reduce costs for small employers by providing subsidies to enrollees that meet specific financial eligibility criteria.
- Minnesota created a stop-loss fund for community purchasing arrangements.
- North Carolina uses rate regulation and tax credits for selected small employers.

Many states also have programs that leverage funds from employers, workers, existing public programs, and other sources

As the cost of health coverage grows every year, it becomes even more important to find and capture every possible dollar that can be used to purchase coverage. Many states are working on efforts to leverage funds from many different sources, including employers, workers, existing public programs, and other sources.

More than 4 in 10 of the states that responded to this section (20 out of 47)³⁸ indicated that they have programs that combine public funds with employer, philanthropic, or individual contributions to pay for health insurance. Some of these efforts might otherwise be called premium assistance (see definition above), and some are programs in which private philanthropies subsidize private insurance premiums for special populations or in certain localities.

- Many counties in California are operating Children’s Health Initiatives (CHI), which combine philanthropic and individual contributions to provide health insurance for children who do not qualify for the state’s health care programs.
- Several counties in Michigan offer “third-share” programs, which share the cost of a premium between the employee, the employer, and the community.
- Tennessee is implementing a “Cover Tennessee” program for the working uninsured that will be funded by three sources: one-third employer, one-third employee, and one-third state premiums.

States also can play a role in providing access to affordable private health coverage by regulating the marketplace

States can use a wide range of strategies to regulate fully-insured group health plans and the individual market, but are prohibited from regulating self-insured plans. Self-insured plans provide the majority of worker coverage in the U.S.³⁹ Here we focus on guarantee issue and rate restrictions on premiums in both the small group and individual health insurance markets. Both of these types of regulations help with access for people who have health conditions – and who may not have an offer of coverage at all or only be offered coverage at very high prices.⁴⁰

One way that states can ensure that people with health conditions at least have an offer of coverage is by requiring insurance to be sold on a guaranteed issue basis. This means that insurers cannot refuse applicants based on age or health status. Another way states can regulate insurance in a way that can benefit people with health conditions is by imposing rating restrictions and prohibiting rating based on health status.

Many states require private health insurance to be offered to the self-employed

Many states go beyond federal minimum requirements to offer protections for the self-employed. Federal law requires that all plans for the small group market be guaranteed issue. This means that small employers (with 2-50 employees) cannot be turned down by insurance companies because someone in the group is sick, although small employers might be ineligible to buy coverage for other reasons. States go beyond these federal requirements by: defining self-employed individuals as “groups of one” (12 states); permitting self-employed individuals to buy health insurance in the small group market on a guaranteed issue basis (14 states); or creating other special rules for groups of one (8 states), such as allowing self-employed individuals guarantee issue to certain insurance products.⁴¹

Fewer states require private health insurance to be offered to other individuals

There is wide variation on what states require in the individual market. In six states⁴² all insurers must continually guarantee the issue of *all* products for at least some individuals.⁴³ In eight states⁴⁴ all insurers must at least periodically guarantee issue *certain* products for at least some individuals. In six states⁴⁵ there is an insurer of last resort that is required to guarantee issue of coverage to residents.

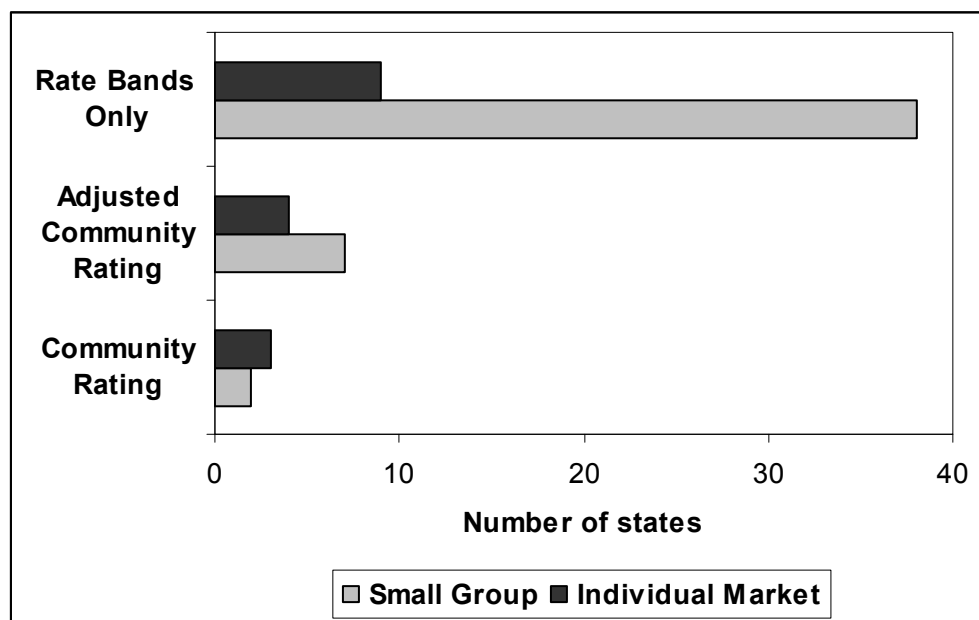
Most states have some type of rate restrictions in the small group market

In the small group market, there is great variety in states’ use of rate restrictions. In two states (New York, Vermont), pure community rating is required, so premiums also cannot vary by age or gender.⁴⁶ Seven states⁴⁷ require adjusted community rating, which means premiums can be adjusted for age or other factors. In addition, 38 states⁴⁸ impose health status rate bands that limit the amount by which premiums can vary due to health status. Rating bands vary substantially across states; in some states, small group premiums can have an added surcharge of more than 100 percent for health status.

Fewer states restrict rates in the individual market

In the individual market, there is also a variety of rating restrictions. In three states (New Jersey, New York, and Vermont), pure community rating is required, so premiums cannot vary by age or gender. Four states (Maine, Massachusetts, Oregon and Washington) require adjusted community rating, which means premiums can be adjusted for age or other factors. Nine states⁴⁹ impose health status rate bands that limit the amount by which premiums can vary due to health status.

Figure 3 State use of rate restrictions in individual and small group markets



States can collect data about health insurance coverage and use this information to inform policymaking

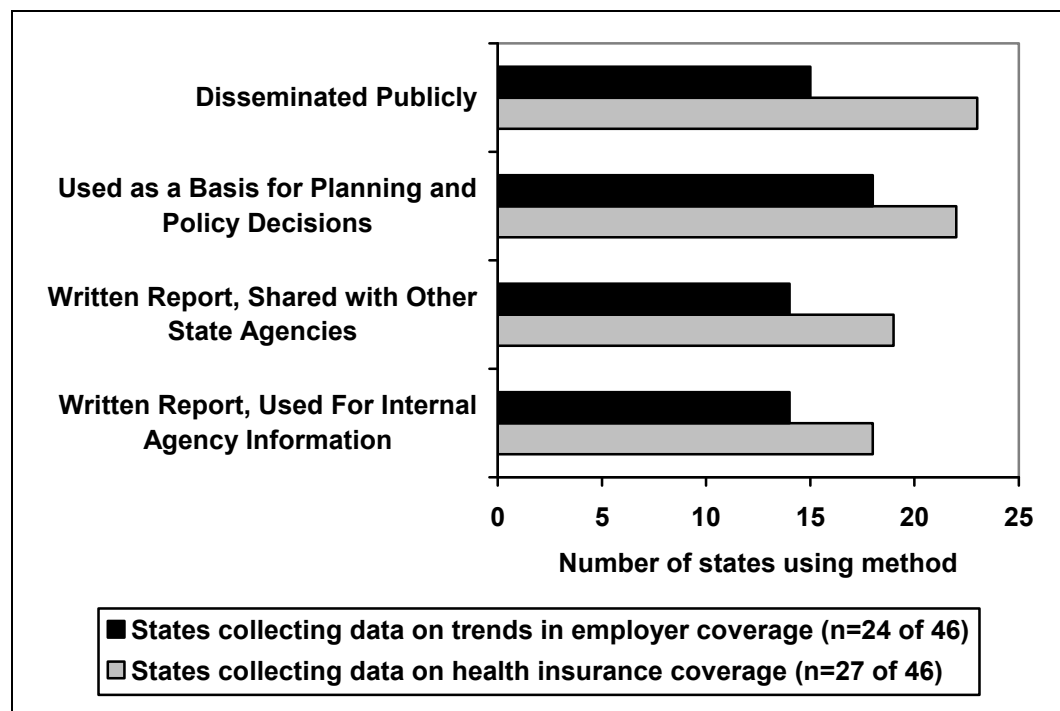
The state role in information collection and monitoring is a particularly important one for states, as most national surveys do not have coverage information that is useful at the state level.⁵⁰ Only two national data collection efforts produce state-level estimates of health insurance coverage. Most national surveys lack adequate sample size to generate good state estimates and sampling approaches that enable analysts to track coverage among important subgroups, such as low-income children. And, many surveys are not timely or regular enough to contribute to real-time state policy decisions.

Many states collect data on health insurance coverage

Over half of states that responded to this section (27 states out of 47) reported that they regularly collect data on health insurance coverage from household or employer surveys. Eighteen states reported that they use this data for internal agency information; 19 states reported that they provide a written report that they share with other state agencies; 22 states use this information as a basis for planning and policy; and 23 states disseminate this information publicly.

States reported using this data to support a range of specific kinds of planning and policy; examples include development of Medicaid waiver applications and other Medicaid reform efforts; planning for coverage expansions, health reform, and universal coverage; and ongoing efforts to understand the health insurance market and develop solutions and proposals to cover the uninsured. States also reported using the data for public health purposes including planning

Figure 4 State use of data collected on employer coverage trends and health insurance coverage



by community health improvement coalitions, ongoing work on health disparities, and development of Federally Qualified Health Centers and free clinics.

Nearly half of states collect data on employer coverage

Over half of states that responded to this section (24 out of 47) reported that they regularly collect data on trends in employer coverage from household or employer surveys. Eleven states reported that they use this data both for internal agency information and for a written report that they share with other state agencies, 18 states said they use this information as a basis for planning and policy, and 15 states disseminate this information publicly. Respondents also reported that in some cases state Departments of Labor also collect data on the offer of employer sponsored health insurance coverage.

Simplifying Enrollment and Improving Retention

Keys to keeping people covered are simplifying enrollment and renewal processes and minimizing the barriers to completing applications or renewing coverage. In many states, many eligible individuals are not enrolled in public health insurance programs. Among uninsured children nationally, as many as three out of four are estimated to be eligible for Medicaid or SCHIP, but not enrolled. The apparent reasons for this include lack of knowledge about available programs and complex forms and procedures for enrollment and renewal.⁵¹ Research and

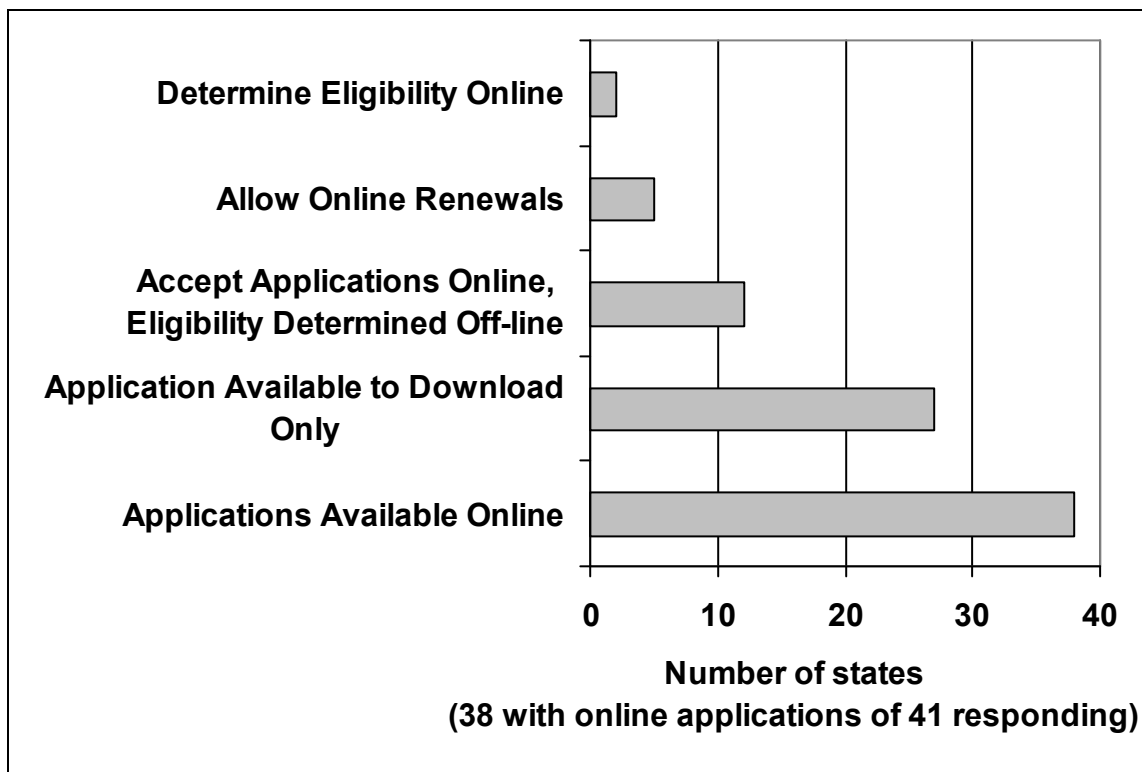
accounts from experts indicate that the biggest hurdle to getting and keeping people on public programs is the complexity of the enrollment and renewal process.⁵² The Commission on a High Performance Health System’s goal of universality will not be reached until there are systems that allow people to easily and efficiently enroll in and maintain coverage, especially if public programs serve as building blocks for comprehensive health reform.

In this section, we examine some key state approaches to enrollment and renewal simplification. These include providing phone and on-line applications, eligibility determinations, and renewals; providing continuous eligibility for children; expediting eligibility for people applying for long-term care services; and administrative renewals.

Most states provide applications on-line, but fewer determine eligibility, link to other programs electronically, or allow renewals on-line

Nearly all of the states that responded to this section of NASHP’s survey (38 states out of 41) indicated that applications for Medicaid or SCHIP programs are available on-line. Two of these states reported that they accept applications and determine eligibility on-line. Twelve states said that the application is accepted on-line but eligibility is determined off-line. Twenty-seven states reported that the application is available to be downloaded only. Five states reported that they allow on-line renewals.

Figure 5 States with on-line Medicaid or SCHIP applications



In addition, 16 states responded that their on-line application is linked to other programs. Responses reflect linkage to a wide variety of programs on-line. SCHIP agencies reported that applications are linked to programs that include Medicaid (including Medicaid family planning programs), the low-income energy assistance program, state-funded health coverage programs, cash assistance, free or reduced price meals, and food stamps. Medicaid agencies reported that applications are linked to SCHIP, WIC, state early intervention programs for children zero to three, and early Head Start.

Integrating on-line program applications: Utah

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. One Web site (www.utahclicks.org) allows families to learn about and apply for programs including Medicaid, Head Start, and SCHIP, 24-hours-a-day, 7-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; that information is used to complete each of the individual applications without unnecessary duplication. The individual applications are then filled in and referred to the appropriate staff for a determination of eligibility. The system allows both intake workers and applicants to review and make changes to documents on-line, reducing printing and postage costs, as well as processing time. The software was developed by researchers at the Utah State University under a 4-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 is also implementing other information technology tools to enhance its enrollment and renewal operations, including an eREP system to automate back-end eligibility determination for multiple programs. 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.

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.

Maturing on-line enrollment technology: California

California was an early adopter of on-line eligibility tools that provided more than simply a downloadable version of the paper application. The Health-e-App web tool, which allows certified application assistants (CAAs) to submit applications and perform real-time eligibility screenings for children and pregnant women, was introduced in San Diego County in 2001. An evaluation of this pilot showed that 95 percent of CAAs and 90 percent of applicants preferred electronic enrollment to paper. In the years since its inception, Health-e-App has matured and been introduced statewide. Now, several players in California are examining ways to expand its use and functionality.

California's 2006-2007 budget included \$9.6 million for improvements in outreach and enrollment, including an effort to expand the use of Health-e-App. The Department of Health Services is in the process of implementing an automated enrollment "gateway" system for families applying to the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). If an uninsured eligible family seeks assistance from California's WIC program, the gateway system will have an electronic interface to find out whether the child is currently receiving Medicaid coverage. If the child is not currently eligible, the gateway system will perform an on-line transaction to provide the child with temporary Medicaid coverage and electronically transfer the application to Medicaid program administrators for a final eligibility determination. The Department also plans to study the benefits of income and asset self-certification in a 2007 pilot.

The California Health Care Foundation, which helped to develop Health-e-App, and The California Endowment, have taken the lead in modifying the software for use by county health departments. Since 2003, seven counties (including Los Angeles as of February 2007) are using the modified One-e-App tool to link their constituents to county indigent care programs and, in three pilot school districts, to free and reduced lunch programs. A module to include screening for the Child Health and Disability Prevention program is under development, and the inclusion of several other programs is being investigated as well.

Source: California Medicaid SHAPES survey response, Health-e-App Resource Website: <http://www.dhs.ca.gov/health-e-App/>, One-e-App website: <http://www.oneeapp.org/>, and 2006-2007 Governor's Budget Summary: http://www.dof.ca.gov/Budget/Budget_2006-07/documents/FullBudgetSummary.pdf.

Simplifying renewals: Pennsylvania

Pennsylvania's Children's Health Insurance Program (CHIP), uses multiple measures to simplify renewal in order to retain eligible children in public coverage. Pennsylvania maintains a 12-month period of continuous enrollment. As a family's time for renewal approaches, CHIP mails out multiple renewal reminder notices at 90 days, 60 days, and 30 days before the deadline. Renewal forms, which the agency recently revised and simplified, are pre-populated with the applicant's information to the extent that systems will allow.

Pennsylvania allows CHIP applicants to renew on-line or by phone. The renewal notices contain an authorization code which can be used on Pennsylvania's COMPASS (Commonwealth of Pennsylvania Access to Social Services) Web site to renew benefits electronically. COMPASS has been enhanced recently to allow electronic signatures, which eliminates the need to fax or mail in a signature page for the renewals. Enrollees can also call the CHIP Helpline and renew over the phone. Helpline representatives key the applicant's information into COMPASS and submit the renewal with an e-signature. Currently, Pennsylvania is developing systems to allow income verification documentation to be submitted electronically.

To prevent enrollees from falling through the cracks, Pennsylvania contracts with a Helpline to call up to 2,000 households a month who fail to respond to the 90- and 60-day renewal letters. Helpline personnel assist with renewals or record the reason why the family is not renewing. Additionally, the CHIP office (located in the Pennsylvania Insurance Department) works with Pennsylvania Medicaid (in the Department of Public Welfare) to narrow the differences between the two programs, to streamline enrollment, and to ease movement from one public program to another. In 2007, Pennsylvania plans to implement an automated electronic referral process to transfer an applicant to and from the Medicaid and SCHIP programs.

*Source: Pennsylvania SCHIP SHAPES survey response and 2005 CHIP Annual Report:
http://www.chipcoverspakids.com/upload/Chip_Resources/Annual_Reports/2005%20SCHIP%20Annual%20Report.pdf*

Table 2 Agency reporting of online applications

State	Application available online		Accepts applications and determines eligibility online		Accepts application online, determines eligibility off-line		Renewal available online		Online application linked to other programs	
	M	S	M	S	M	S	M	S	M	S
	(M=Medicaid, S= Separate SCHIP)									
Alabama	•	•		•	•				•	•
Alaska	•									
Arizona	•	•								
California	•	•							•	•
Colorado	•	•								
Connecticut	•									
Delaware		•								
Dist. of Col.	•									
Florida	•				•		•			
Georgia	•	•			•	•				
Idaho	•									
Illinois		•				•				•
Iowa	•	•				•		•		
Louisiana	•									
Maine		•								•
Massachusetts	•	•			•	•	•		•	•
Michigan	•		•						•	
Minnesota	•								•	
Missouri	•									
Montana	•	•								
Nebraska	•								•	
Nevada	•	•				•				
N. Hampshire		•								
New Jersey	•				•				•	
New York	•									
North Carolina		•								
Ohio	•									
Oklahoma	•								•	
Oregon	•								•	
Pennsylvania		•						•		•
South Carolina	•									
Texas	•	•			•				•	
Utah	•	•			•	•			•	
Vermont		•								
Virginia	•									
Washington	•	•			•	•	•	•		•
Wisconsin	•				•				•	
Wyoming	•	•								
Total (n= 38 of 41 states responding)	31	20	1	1	9	7	3	3	12	7

Many states provide continuous eligibility for children

Federal law for both Medicaid and SCHIP requires that an eligibility review be done at least once each year, but states may choose to review more frequently. Even if eligibility is reviewed once a year, in general beneficiaries are required to report changes in income and other family circumstances in the interim. However, many Medicaid and SCHIP programs have expanded children's coverage by implementing "continuous eligibility" policies that guarantee children retain eligibility for up to one year regardless of fluctuations in family income or structure. According to a previous SCHIP survey conducted by NASHP, as of 2005, 16 out of 32 states with *Medicaid expansion* SCHIP programs were using "continuous eligibility."⁵³ In addition, most *separate SCHIP* programs (27 out of 36) were using continuous eligibility.⁵⁴

Some states are using "administrative renewals"

"Administrative renewals" allow families to stay enrolled in coverage without being required to submit new income or other eligibility information to the state. Instead, the state either sends the family a pre-printed renewal form and asks them to return the form only if information needs to be updated, or gathers needed information from other agencies and programs in order to ascertain eligibility.

Nine states⁵⁵ out of 35 that responded to our survey indicated that they conduct Medicaid administrative renewals for children.⁵⁶ Seven states⁵⁷ reported that they send preprinted forms to recipients that are to be returned if there are any changes. At least five states (Colorado, Louisiana, Tennessee, Virginia, and Wyoming) gather information from other agencies and programs – such as the state department of labor, to ascertain eligibility. Some states use a combination of approaches, and also include outbound phone calls made to certain populations if their renewal form is not received by a certain date.

In addition to administrative renewals for children, Alabama's Medicaid program responded that it conducts administrative renewals for individuals who are over a certain age and on fixed incomes. The state sends a form and asks for it to be returned only if there is any change since the last review.

Some states have expedited eligibility for people needing long-term care services

A delay in determining financial eligibility may dictate whether a person remains in a community setting or enters a nursing facility. Although current federal policy does not allow states to receive federal reimbursement for services delivered to applicants needing long-term care services while their eligibility is being decided, some states have recognized the importance of determining financial eligibility quickly.⁵⁸ States have expedited eligibility both by providing presumptive eligibility and by "fast-tracking" eligibility. Both of these options address the factors that are most likely to cause delays – fully completing the application and providing the necessary documentation.

Previous work by NASHP identified at least eight states as of 2004 that had programs in place to expedite eligibility for people needing long-term care services.⁵⁹ At least six states⁶⁰ have presumptive eligibility for these individuals, at least on a pilot basis, despite the lack of federal

reimbursement for erroneous decisions. This policy allows eligibility workers or case managers, nurses, or social workers responsible for functional assessments and level of care decisions to decide whether the individual is likely to be financially eligible. They can then initiate services before the official determination has been made by the eligibility staff.

At least two states (Colorado and Georgia) have implemented pilot projects to “fast-track” eligibility decisions. These states speed up eligibility decisions by assigning responsibility for determining Medicaid eligibility to the same agency that manages Medicaid long-term care services. This organizational arrangement gives the agency responsible for all long-term care policy and management responsibility better and more timely control over eligibility determinations, and therefore access to services.

Addressing Benefits for Essential Health Services

The Commission on a High Performance Health System has recognized the importance of ensuring that people get “the right care – care that is known to be effective – as needed for prevention, treatment, or palliation.” Such care is an essential ingredient for quality of health care, and established benefits are important to people’s ability to obtain the right care. There are many ways that states can ensure that public and private health coverage provides benefits for essential health care services. For the purposes of this survey, we identified and examined a select number of approaches.

For the private marketplace, states can require fully-insured health plans to provide a minimum package of benefits in the individual and small group markets. States also can monitor the market place and use this information to identify and address benefit issues. States can act to prohibit insurers from discriminating, as between physical and mental health disorders. In public programs, states can provide optional benefits, such as dental benefits for adult Medicaid beneficiaries and for children enrolled in SCHIP.

Many states require minimum benefit packages in the private market

States can influence benefits packages provided in the private health insurance market. One approach to ensuring that residents have access to critical health care services is for a state to require a minimum benefit package for the individual market and the fully-insured small group market.⁶¹

More than half of states that responded to our survey (18 out of 34) indicated that they require a minimum benefit package – not just specific mandated benefits – for the individual or small group market.⁶² Two states specified that these benefit packages were based on national recommendations, such as National Association of Insurance Commissioners (NAIC) model laws. Ten states said their benefit packages were based on state advisory group recommendations; none indicated that these were based on Medicaid benefits. For example:

- Florida requires small group carriers to offer two options, a pre-defined standard and a basic benefit plan. Florida’s small group statute defines the membership of a Committee

that can be called by the state's chief financial officer whenever the Office of Insurance Regulation determines that modifications are necessary.

- In Oregon, every insurer selling small group insurance in the state must offer a basic benefits package developed and approved by the Health Insurance Reform Advisory Committee (HIRAC) and the Insurance Administrator. HIRAC is composed of insurers, purchasers, consumers, and state agencies.
- In New Jersey, the Small Employer Health Benefits Program Board includes representatives of carriers, employers, brokers, labor, physicians, and the Commissioners of Banking and Insurance, and Health and Senior Services. The package is a comprehensive major medical plan. Standard plans may be amended with riders of increasing value or decreasing value.
- In Minnesota, all health carriers must offer to employers, individuals, and families a Qualified Health Insurance Plan of comprehensive health coverage.
- In Maine, both the individual and the HMO managed care markets are required to provide a minimum benefit package.

Benefit standards and competing concerns: 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 regulates 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 sometimes faces difficult choices between competing priorities.

The Maryland Health Care Commission (MHCC, mhcc.maryland.gov/) 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 2 and 50 employees) buy in to the nine participating health plans, which provided coverage for 448,000 people in 2005. The standard plan is a comprehensive plan, including most services and organ transplant services. Insurers must offer modified community rating, meaning that 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.

By law, standard plan benefits must be priced 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 maintain catastrophic coverage for generic and brand-name drugs, with a \$2,500 annual deductible for single coverage, a \$5,000 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, MHCC Summary of Carrier Experience, Year Ending December 31, 2005: 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

Table 3 Insurance agency reporting of required benefit package design

State	Benefit package based on national recommendations	Benefit package based on state advisory group recommendations	Other
Alaska		•	
Colorado		•	
Florida		•	
Hawaii			•
Idaho		•	
Iowa	•		
Maine			•
Maryland		•	
Minnesota			•
Missouri			•
Nebraska	•	•	
New Jersey		•	
New Mexico		•	
Oklahoma			•
Oregon		•	
South Carolina			•
Tennessee		•	
Virginia			•
Total (n=18 of 34 responding states)	2	10	7

Fewer states monitor trends in features of private market products

Nine states⁶³ out of 34 that responded to this section indicated that they monitor trends in features of private insurance market products. Such features include deductibles, out-of-pocket costs, and benefit design. One state that responded uses the information for a written report for internal agency information, one state shares it with other state agencies, four use it as a basis for planning and policy development, and two disseminate the information publicly.

- Colorado conducts a biennial survey to determine small group Basic and Standard benefit designs.
- In Florida, the monitoring is informal, but serves as the basis for recommending the appointment of a new committee to update the small employer “standard” and “basic” plans.
- In Minnesota, the Department of Health's Health Economics Program conducts research and applied policy analysis to monitor changes in the Minnesota health care market and to study factors that influence health care costs, quality, and access. The agency uses the information to provide technical assistance in the development of state health care policy.
- In Hawaii, the Department of Labor and Industrial Relations monitors all plan changes to ensure conformance with the prevalent plan. Under the Prepaid Health Care Act, Hawaii

requires plans to offer the benefit equivalent of the most prevalent plan (the plan with the most members).

The majority of states have a mental health parity law

Services for mental health conditions are a major area of unmet need in the United States. Lack of coverage, lack of providers, and other barriers contribute to this problem. 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. Research has shown that mental health benefits can be offered on par with other medical services without significantly increasing health insurance premiums. However, parity also has been shown to have little effect on the use of mental health treatment. Recent research has found that living in a parity state significantly reduces the financial burden on families with children with mental health needs. Specifically, the likelihood of a child's annual out-of-pocket health care spending exceeding \$1,000 was significantly lower among families living in parity states compared with those in non-parity states.⁶⁴

According to Mental Health America, 38 states have enacted some type of mental health parity law.⁶⁵ Five states (Connecticut, Maryland, Minnesota, Vermont, and Oregon) have passed the broadest mental health parity laws, requiring health plans that offer coverage for medical and surgical conditions to offer coverage for the diagnosis and treatment of mental or nervous conditions. These laws apply to all mental health and substance abuse disorders for all private insurance plans, with no exceptions. Six states (Indiana, Kentucky, Maine, New Mexico, Rhode Island, and Washington) have passed laws which have exceptions due to size of employer, or which limit substance abuse services. Fourteen states⁶⁶ have more limited parity laws that apply only to select groups of individuals such as those with severe mental illness or state and local employees, or only protect against certain kinds of discrimination. An additional 13 states⁶⁷ have even more limited parity laws.

Most states provide at least some limited Medicaid dental coverage for adults

While public health interventions like community water fluoridation have improved the oral health status of most Americans, low-income people, particularly those dependent on programs like Medicaid, have difficulty maintaining oral health and finding access to needed care. A 2000 Surgeon General's report labeled oral disease a "silent epidemic" that is five times more prevalent than asthma in children.⁶⁸ Oral infections can lead to costly or catastrophic outcomes; an abscessed tooth can spread infection through the bloodstream, leading to hospitalization or even death. Additionally, emerging research indicates a correlation between gum disease and systemic conditions such as pre-diabetes and heart disease, as well as pneumonia among nursing home residents.⁶⁹

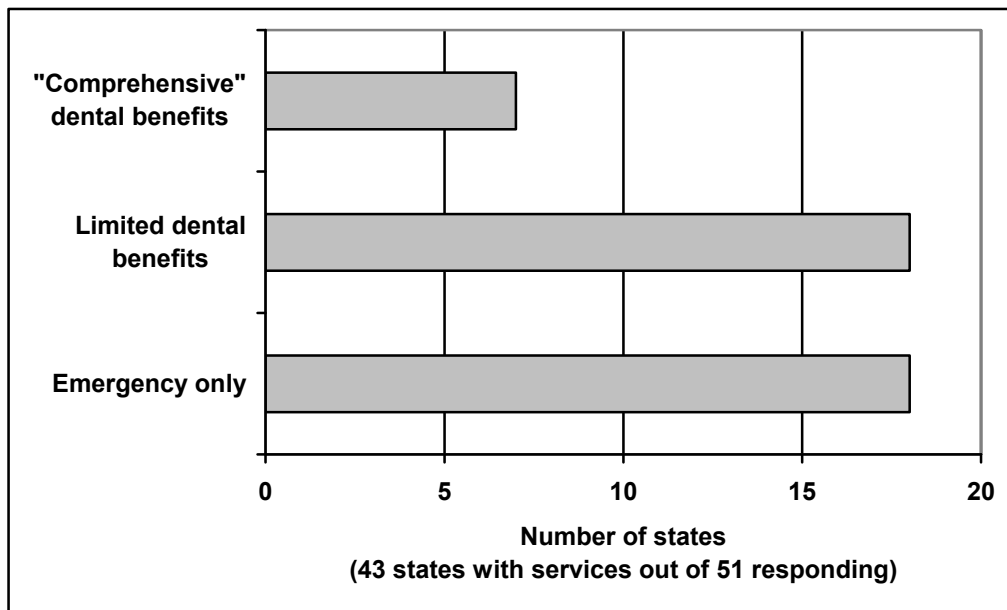
States are required to provide comprehensive dental care to Medicaid-enrolled children under the auspices of the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit. While dental coverage is optional for children enrolled in separate SCHIP programs, currently all states have at least some dental benefits for this population.⁷⁰ However, many states are more

restrictive in regard to coverage of dental benefits for adults, an area frequently seen as a place for state programs to trim back.

Despite this trend, as of 2005, 43 states continue to provide at least some limited dental coverage for adults.⁷¹ Of these, 7 states⁷² offer adult dental benefits that are “comprehensive” and include coverage of preventive (routine cleanings) and restorative services (fillings). Eighteen states⁷³ offer adult dental benefits that are limited in scope or have a yearly dollar cap. Eighteen states cover only emergency services, most frequently defined as coverage of tooth extractions and care that relieves pain.⁷⁴

The dental provider community frequently cites inadequate reimbursement and cumbersome paperwork as reasons for limited participation in Medicaid and SCHIP. States such as Tennessee and Michigan have made improvements in dental access by contracting with specialty vendors for dental claims processing, and by making significant increases in dental reimbursement rates.⁷⁵

Figure 6 States covering adult dental services in Medicaid, 2005



Source: Medicaid/SCHIP Dental Association. Adult Dental Benefits in Medicaid: FY 2000, 2002, 2003, 2004 & 2005. (not dated); Retrieved 13 March 2007. <http://www.medicaidental.org/Docs/AdultDentalBenefits2003.pdf>.

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QUALITY, EFFICIENCY, AND VALUE

Introduction

Many stakeholders concerned about the quality of health care in the U.S. believe that public reporting, pay for performance, and quality improvement initiatives can drive the change needed to improve that quality. According to the Commission for a High Performance Health System, implementing major known quality and safety improvements, increasing public reporting on quality and costs, and rewarding performance for quality and efficiency through payment systems are concrete steps that could improve the value of health care in the United States.⁷⁶

Based on available evidence, there is a wide gap between the quality of health care services that Americans receive and the care that should be provided. Quality of care is highly variable and often poorly coordinated.⁷⁷ According to the Institute of Medicine (IOM), as many as 98,000 hospitalized patients die annually as the result of errors, more than the number of deaths due to motor vehicle or workplace accidents, AIDS, or breast cancer. More than half of these deaths are preventable – in many cases evidence-based methods are available that can prevent them.⁷⁸ Since the release of these numbers, major studies have substantiated errors in other care settings, including ambulatory care settings and nursing homes, as well as errors of omission,⁷⁹ one major study found that patients receive only 55 percent of recommended care.⁸⁰

Medical errors and poor quality care carry significant financial costs in addition to human costs. The IOM estimated the total costs of preventable adverse events to be between \$17 billion and \$29 billion, with health care costs representing more than half of these costs.⁸¹ The costs of poor quality care have been estimated at \$420 billion for direct care and between \$150 billion and \$210 billion in indirect costs.⁸²

Increasingly, states are interested in measuring and improving health care quality, in part in efforts to reduce costs. Most Medicaid and SCHIP agencies are measuring performance and undertaking quality improvement activities, according to a 2006 study.⁸³

States have significant influence over health care system performance as regulators of insurers and medical providers and as purchasers of health care. They can use these levers to establish expectations; gather and analyze information needed to identify quality problems and their causes; and require, encourage, and reward provider efforts to improve quality and patient safety. States have many opportunities to improve quality and patient safety and safeguard the public. They can encourage transparency through public reporting to drive quality improvement; reward high quality, safe performance; encourage correction of poor performance through purchasing decisions; and coordinate with other state agencies and partner with the private sector on quality initiatives.

This section examines initiatives by states to address health care quality, efficiency, and value through these mechanisms. State efforts to address patient safety through these means were given special attention.

Providing Leadership within Quality Collaboratives, Agendas, and Forums

Background

There are numerous activities that state governments can take independently as public agencies, and in partnership with providers, consumers, and purchasers, to fulfill their responsibility to protect the public's health and safety.

Many state agencies have a role in improving health care quality as regulators, purchasers and providers of care. However, there is often no focal point for state efforts to address quality; state responsibility for quality tends to be spread across an array of professional licensure boards, licensing and certification agencies, Medicaid, insurance, public health, and other departments. Without a natural vehicle to organize quality activities, state efforts may be fragmented. Some states have developed quality collaboratives, agendas, and forums to craft coordinated strategies.

A state's leverage to drive quality improvements and efficiencies in the health care system may be enhanced by partnering with the private sector. Some state agencies have joined public/private initiatives to address quality and patient safety as opposed to undertaking independent initiatives.

NASHP surveyed governors' offices and public health agencies about their state government's role in multi-agency and multi-sector efforts to improve health care quality. Agencies in 33 states responded to this component of the survey.

State quality collaboratives involve multiple agencies

Nine states indicated that they have a plan or agenda developed by the executive branch of government for health system quality improvements and a structure or mechanism (such as a task force) specifically for state agency collaboration on health system quality improvement (Arizona, Arkansas, California, Maine, New Mexico, Pennsylvania, Rhode Island, South Dakota, Virginia). These include, for example, the Arkansas Center for Health Improvement, Maine Quality Forum, and the New Mexico Governor's Performance and Accountability Contract and Comprehensive Strategic Health Plan. A few additional states have either a plan (Alabama, North Carolina) or a structure (Wisconsin) but not both. Several other states indicated that plans are being developed.

Of the ten states with a structure, in most cases participants include the governor's office, public health agency, cabinet-level superstructure, and Medicaid agency. Just over half also include the state employee benefits and insurance agencies.

Table 4 State collaboratives and plans

State	Plan/agenda	Structure or task force
Alabama	•	
Arizona	•	•
Arkansas	•	•
California	•	•
Maine	•	•
New Mexico	•	•
N. Carolina	•	
Pennsylvania	•	•
Rhode Island	•	•
S. Dakota	•	•
Virginia	•	•
Wisconsin		•
Total (12 of 33 responding)	11	10

State respondents offered the following examples of state task forces and their leadership:

- New Mexico's Health and Human Services Department secretaries meet weekly to monitor progress on each of the Governor's health and human services goals. One of the six major goals is to improve access, quality, and value for public behavioral health services. This area is overseen by the Behavioral Health Collaborative, a structure set in statute, composed of 15 agencies and the Governor's Office. Collaboration among the four Health and Human Services Departments (Health; Human Services; Aging and Long-Term Services; and Children, Youth and Families) is encouraged by the Governor at the cabinet level.
- In Pennsylvania, all seven cabinets involved in health care delivery were pulled together under the guidance of the Office of Health Care Reform (GOHCR).

Many states are participating in public- private quality collaboratives.

Twenty-one states reported participating in a public-private collaborative or forum for the purpose of improving quality of health care (Arizona, Arkansas, California, Connecticut, Florida, Idaho, Louisiana, Maine, Massachusetts, New Mexico, North Carolina, North Dakota, Ohio, Oregon, Pennsylvania, South Dakota, Utah, Virginia, West Virginia, Wisconsin, and Wyoming). Of these, 12 report that the state is the convener. Just under half of states report that the state authorized the collaborative through legislation (9), and that the state provides funding (8) and technical assistance (7). Maine is the only state in which the state functions in all of these capacities.

In terms of their focus, the majority of public-private collaboratives have focused on clinical effectiveness (15) and efficiency (11). Fewer have focused on patient satisfaction (9) or other issues.

The majority (15) of the collaboratives have coordinated public-private activities. Many (10) have provided information and education for consumers, usually through a Web site or written materials. Some (7) have developed policy recommendations and provided information for providers (8). Several states also mentioned that they have focused on health information technology, disease management, or various aspects of patient safety, such as medication errors and fall prevention.

For example:

- Arizona has coordinated public-private activities in the use of technology to improve patient safety and provider efficiency
- Connecticut has provided best practices for screening for breast cancer and medication reconciliation and developed policy recommendations
- Maine has several public-private partnerships that focus on quality.

Providing leadership within quality collaboratives, agendas, and forums in Oregon

The Oregon Health Policy Commission was created by the Oregon Legislature in 2003 as a public body that would 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 over the years since its inception. The 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. Its Quality and Transparency Workgroup was a 23-member panel of representatives from private insurance, public-sector insurance, academia, and service providers. This workgroup met, and continues to meet, almost monthly to discuss recommendations on subjects such as electronic health records, protecting the confidentiality of patient records, and disseminating quality information.

The Oregon Health Care Quality Corporation, which participates in the Quality and Transparency workgroup, has been a leader in the effort to develop evidence-based Common Measures for improvement in the treatment of conditions such as asthma, cardiovascular disease, diabetes, and depression. (The Quality Corporation is itself a collaborative led by a board of public and private health-sector stakeholders.) 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 to collection of outpatient primary care Common Measures statewide. The Oregon's Governor's Office reports that discussions are currently ongoing on a possible RFI and cost assessment to implement them.

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

Several other examples of quality collaborative that were not explored through the survey include:

- At least six states have enacted legislation supporting the creation of a state patient safety center (Florida, Massachusetts, Maryland, New York, Oregon, and Pennsylvania). All six include promoting collaboration between the public and private sectors as a goal of the center, and three also intend to coordinate state agency initiatives.⁸⁴ By consolidating and coordinating requirements, the state can speak with one voice for patient safety and reduce conflicting or duplicative requirements placed upon providers.

Publicly Reporting Patient Safety and Health Care Quality Measures

Background

Public reporting of data that measure aspects of system performance is an important component of system capacity to reach and sustain excellence. Public reporting is a critical ingredient for system accountability and a necessary tool for consumer choice and has been cited as an effective way to spur health care quality improvements.⁸⁵

Among its calls for public reporting, the Institute of Medicine called on every state government to create a mandatory reporting system to collect information about adverse events that result in death or serious harm. In discussing the need to foster innovation and improve the delivery of care, the Institute of Medicine continued its call for public accountability by emphasizing transparency as one of ten principles that should guide the redesign of the health care system.⁸⁶

Almost all states require that health care data be collected, analyzed, and distributed. The reasons that a state may choose to publicly release data are varied and include assuring accountability for health care quality, providing information to consumers about health care facility quality, improving public trust, and creating pressure to drive change and enhance quality of care.

NASHP surveyed governors' offices and public health agencies about the scope and characteristics of patient safety and quality public reporting in the states. Agencies in 33 states responded to this component of the survey.

Public reporting of quality information occurs in about half of states that responded

Fourteen states⁸⁷ reported having a legislative mandate for quality data reporting. Eleven⁸⁸ reported a non-mandated activity regarding quality reporting. Seven of these states overlap: California, Connecticut, Maine, Massachusetts, New Mexico, Oregon and Wisconsin.

Of the non-mandated activities, the state's role is most frequently to collect data (7), publicly report data (6), and serve in an advisory capacity (7). The state less frequently contracts with a private entity for data collection/reporting (4) or provides funding (3).

- In Arkansas, the State Employee / Public School Employee Board committee examines quality of care provided to 10 percent of state-insured workforce.
- In Connecticut, a study of cardiac and health care acquired infections is mandated; final recommendations may include non-mandated initiatives (for example, convening a stakeholders' quarterly meeting to share best practices).
- The state of Oregon is the convener of public-private stakeholder input to review the quality measures analysis and reporting methodology, and is working on consumer-friendly versions.

Publicly reported data is generated from both provider and payor data

In five states, all payors are required to supply quality data to state collection efforts (Kentucky, New Jersey, Oregon, Pennsylvania, and Rhode Island). Of those with requirements only for select payors, Medicaid, separate SCHIP and state employee health plans were mentioned almost equally (5, 4, and 5 respectively). In ten states,⁸⁹ one or more agencies publicly report quality data collected from multiple payors. The public health agency was mentioned most frequently (5).

- In Missouri, Medicaid separate SCHIP, private health plans, and the hospital association all supply quality data to state collection efforts.
- New Mexico collects information from Medicaid, state employee health plan, and private health plans.

Hospitals are the most likely to provide quality data, including inpatient data in 14 states, outpatient data in 9 states, and emergency department data in 6 states. Health plans also provide data in 9 states. Data from physicians (5) and nursing homes (6) was less common. Several states also mentioned ambulatory surgical centers. According to a previous survey, more than half of surveyed Medicaid programs (26 of 47 programs) publish performance results of providers, usually limited to managed care organizations rather than specific institutions or health care professionals.⁹⁰

- Hospitals (inpatient, outpatient, and emergency department), health plans, physicians, nursing homes, community health centers, and local health departments all provide data for public reporting in New Mexico.
- Oregon currently collects inpatient data from hospitals and some survey data on nursing facilities and ambulatory surgical centers; the state will collect hospital outpatient and ambulatory surgical center claims data by the middle of 2007.

Reported information tends to be drawn from hospital discharge data (13) rather than from paid claims data (5) or medical chart review (6). States also draw information from surveys, Healthcare Effectiveness Data and Information Set (HEDIS) data, and facility reports.

State quality reporting includes national and state- developed measures

Fifteen states⁹¹ reported that their quality reporting includes national measures. Six of these states also reported using state-developed measures (California, Massachusetts, New Jersey, New Mexico, Utah, and Virginia). Five states include measures specific to children (California, Missouri, New Jersey, New Mexico, and Oklahoma). Immunizations were mentioned most frequently, but other measures include obesity, teenage pregnancy, youth suicide, asthma medications, upper respiratory infections (URIs), well child care, and preventable hospitalizations.

- California reports on immunizations, asthma medications, throat infections, URIs, well child care, and preventable hospitalizations.
- New Mexico reports on immunization, obesity, teenage pregnancy and youth suicide.

States disseminate quality data most frequently through websites

Fourteen states⁹² indicated that they report quality data via Web sites. According to a previous survey, 20 states have at least one comparative hospital performance Web site, although most include HEDIS measures and/or CAHPS surveys only.⁹³ Of these, 11 have a government mandate to report hospital quality information to the public.⁹⁴

Of the fourteen states that reported a Web site, all but Kentucky, Massachusetts, Missouri, and Wisconsin also produce a written report. One state, Pennsylvania, produces a written report but does not have a Web site posting. Several states reported having a media campaign (Maine) or a toll-free phone line (New Mexico) to report data, and two states noted that information is available upon request (New Mexico, Ohio). Several states have undertaken initiatives to make their information more accessible, including providing consumer training, producing their reports in languages other than English, conducting literacy testing, or having had section 508 complaints filed to ensure compliance with Federal law that requires electronic and information technology to be accessible to people with disabilities. California, Maine, New Mexico, and Rhode Island use two or more of these methods.

- California and New Jersey report quality data on Web sites, in written reports, through media campaigns, and toll-free phone lines. California conducted focus groups to ensure usability of its information.

Quality reporting focuses most frequently on clinical effectiveness

Clinical effectiveness measures are the most common quality measures reported (14 states), followed by patient satisfaction (9 states). Efficiency measures were not commonly reported (3 states). Some states reported use of AHRQ quality measures.⁹⁵

- California reports on clinical effectiveness, patient satisfaction, HEDIS, and CAHPS. New Jersey also mentioned HEDIS and CAHPS.
- Kentucky and Oregon report on AHRQ quality measures.

- New Jersey produces hospital quality reports based on CMS process of care measures and cardiac surgery mortality report.

Public reporting of patient safety data is less common than overall quality reporting

According to the survey respondents, there is a legislative mandate to publicly report data on measures of patient safety in 8 states (Connecticut, Maine, Massachusetts, New Jersey, Oklahoma, Oregon, Pennsylvania, Virginia). (Many of these states also have a mandate to report quality information, but the list of states is not an exact overlap). There are an additional four states (Arkansas, New Mexico, Utah, and Wisconsin) that participate in non-mandated activity regarding patient safety data reporting. Some states reported both mandated and non-mandated reporting.

- The Maine Quality Forum has launched the Safety Star program to identify and promote hospitals that meet safety standards.
- The Oregon State Public Health Officer provides annual certification of the hospital reporting and integrity of the Patient Safety Reporting Program of the Oregon Patient Safety Commission, a semi-independent state agency.

Figure 7 Publicly reported quality and safety information: State-mandated and non-mandated

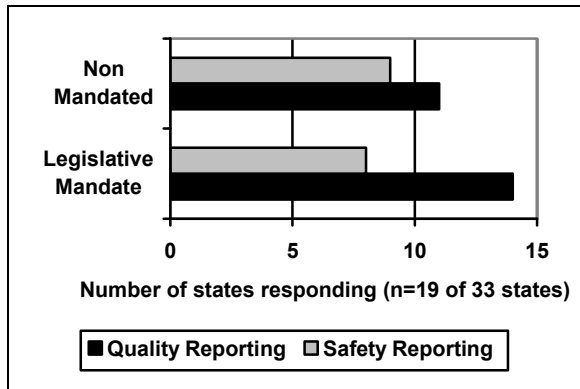


Table 5 States that publicly report quality and safety information

State	Legislative mandate to report quality information	Legislative mandate to report safety information	Quality reporting not mandated by legislation	Safety reporting not mandated by legislation
Arkansas			•	•
California	•		•	
Connecticut	•	•	•	
Idaho			•	
Kentucky	•			
Maine	•	•	•	•
Massachusetts	•	•	•	•
Missouri	•			
New Jersey		•		
New Mexico	•		•	•
Ohio	•			
Oklahoma		•	•	•
Oregon	•	•	•	•
Pennsylvania	•	•		•
Rhode Island	•			
South Dakota			•	
Utah	•			•
Virginia	•	•		
Wisconsin	•		•	•
Total (n=19 of 33 states)	14	8	11	9

As with quality information, providers, rather than payors, are more frequently reporting patient safety data

In most states, providers, not payors, are required to report patient safety data. However, Arizona requires the Medicaid agency to report, Delaware requires the state employee health agency to report, and New Jersey is the only state that indicated all payors are required to supply patient safety data to state collection efforts.

- Only eight Medicaid programs have hospital inpatient measures for any combination of patient safety process, serious reportable events, or infrastructure/structure measures included in their quality monitoring activities.⁹⁶

Of providers, hospitals are the most common data reporters; nine states collect data from the inpatient setting and six from the outpatient setting. Several states also report data from ambulatory surgical centers, nursing homes, and health plans.

Not surprisingly, the data tend to be extracted most commonly from hospital discharge data (7) rather than paid claims data (1) or medical chart review (3). Several states also mentioned hospital incident, or adverse event, reporting systems.

- More than half of the states (27) have passed legislation or enacted regulations related to hospital reporting of adverse events,⁹⁷ although the degree of public reporting varies. Seventeen states have issued, or plan to issue, public reports with information about patient safety. The public reports that have been issued can be accessed at NASHP's www.pstoolbox.org. Some reporting is aggregate and some is institution specific.

Eight states (Arkansas, California, Connecticut, Maine, Massachusetts, New Jersey, Ohio, Virginia) responded that state patient safety reporting includes national measures, while five states include state-developed measures (California, Connecticut, Maine, Massachusetts, New Mexico).

- Maine and Nebraska include measures specific to children (abduction, and seatbelt usage/injury data specifically).
- Nine states use, or plan to use, the National Quality Forum's list of serious reportable events developed through a voluntary consensus process (California, Connecticut, Illinois, Indiana, Minnesota, New Jersey, Oregon, Washington, and Wyoming). In many of these states, the system has yet to be implemented using this list of events.⁹⁸

Seven states publicly report patient safety data by Web site (Connecticut, Maine, Massachusetts, Nebraska, New Jersey, New Mexico, Wisconsin); of these, all but Wisconsin also produces a written report. One state, Arkansas, produces a written report but does not have a Web site posting. The survey did not specify the type of data that is reportable, and whether it is reportable in aggregate form or on an individual institution level. Other sources reveal an additional six states with reports available by Web site: Colorado, Florida, Minnesota, New York, Pennsylvania, and Tennessee.⁹⁹

- Minnesota produces an annual report with facility-specific data about adverse events and a Consumer Guide to Adverse Health Events, designed to help consumers consider questions they should ask about their care, activities that facilities should undertake to keep patients safe, and information about adverse events that have occurred and efforts underway to prevent recurrences. The Minnesota Alliance for Patient Safety received the 2006 John W. Eisenberg Patient Safety and Quality Award for its work in creating a more transparent and accountable health care system and its efforts to reduce adverse events.
- New Mexico produces its report in languages other than English to be more accessible.
- NASHP compiled information on state adverse event reporting systems and developed a state patient safety toolbox. Public Web-accessible reports are available at the site, www.pstoolbox.org.

Public reporting of quality and safety indicators: A multi-pronged quality initiative in Maine

Maine takes quality seriously. Improvement in quality measurement, public reporting of data, and identification of high achievers are central elements of the state's strategy to understand its health care delivery systems and improve outcomes. The work of several entities provides Mainers with a wide variety of information on the quality of care provided by the state's doctors, hospitals, and health care payors.

The Maine Quality Forum (www.mainequalityforum.gov), established by the state legislature in 2003 as part of Maine's Dirigo health care reform effort, seeks to improve the data that is made public to health care consumers, so as to 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 of conditions 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 of any patient 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 the safest.

The Maine Health Management Coalition (www.mhmc.info), a 34-member coalition of providers, insurers (including the state employee health plan), and public and private employers, has as its mission to measure and report on the value of health care services. It provides rankings of the state's doctors and hospitals that are publicly available 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 can 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 that maintains a publicly accessible database of health information. It 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 websites noted above.

Leveraging Purchasing Power Through Contract Requirements and Joint Purchasing

Background

Purchasing for quality is becoming of increasing interest to public and private purchasers. Purchasers pay for poor quality care when insurance costs and co-payments increase as the result of overuse, under use, and misuse of health care services. Purchasers can use their leverage to improve quality and patient safety by rewarding high quality, safe performance and encouraging correction of poor performance. Payment incentives can reward more effective and efficient care, with a focus on value.¹⁰⁰

Since states purchase health care for a sizable share of the market, they have a significant opportunity to influence the quality and safety of health care. The Medicaid and SCHIP programs spend more than \$320 billion per year in state and federal funding, placing Medicaid and SCHIP among the country's major purchasers of health care, accounting for one-sixth of all health care spending in the U.S.¹⁰¹

Contract requirements

NASHP surveyed Medicaid, SCHIP, and state employee health plans (SEHP) about contract requirements in the areas of patient safety and quality measures, performance incentives and disincentives, disease and care management programs, cultural competency, and EPSDT. Agencies in 43 states responded to this component of the survey, including 35 Medicaid, 23 separate SCHIP, and 17 state employee health agencies. Almost all agencies reported contracting with plans or physicians to manage primary care, including 30 Medicaid, 7 SCHIP, and 14 SEHPs. These states responded to the following questions about contract requirements.

Most state agencies require reporting on quality measures

Most states' contracts require reporting on quality measures; agencies in 29 states reported that all contracts require quality measurement reporting, including 25 Medicaid agencies, 7 separate SCHIP programs, and 7 state employee health plans. In nine states (California, Connecticut, Colorado, Massachusetts, New York, Tennessee, Texas, Utah, Wisconsin), more than one agency reported doing so. State agencies in seven states require such reporting in some contracts. However, according to other sources, most Medicaid and SCHIP agencies (30 of 47) do not collect hospital inpatient performance data.¹⁰²

- The Alabama SCHIP program requires reporting of patient satisfaction, response timeliness, complaint resolution, appropriate use of asthma medication, and well-child visits.
- Five Medicaid programs (Alabama, Arkansas, Massachusetts, North Dakota, and Pennsylvania) appear most involved in hospital inpatient quality measurement and improvement efforts.

Clinical effectiveness and patient satisfaction are common quality measures

Medicaid, SCHIP, and SEHPs are almost equally likely to require clinical effectiveness (27, 6, and 10 agencies, respectively) and patient satisfaction (25, 6, 9 agencies, respectively) quality measures. Several Medicaid and SCHIP agencies mentioned HEDIS and preventive care measures, which matches a previous survey finding that HEDIS measures are a very common feature of quality performance measurement in Medicaid and SCHIP programs.¹⁰³ These results are not surprising, given that CMS has adopted a list of seven recommended HEDIS performance measures for Medicaid and SCHIP programs. CMS requires SCHIP programs to submit an annual report with data for these measures or plan to collect such data.¹⁰⁴

All respondents use nationally developed quality measurement sets

Of the agencies that require reporting on quality measures, every Medicaid, SCHIP, and SEHP that responded (26, 8, 11 agencies, respectively) uses nationally developed or endorsed measurement sets, such as those from AHRQ, CMS, HEDIS, JCAHO, CAHPS, and NQF; 18 Medicaid, 2 SCHIP, and 5 SEHPs also use state-developed measures, and 23 Medicaid, 6 SCHIP, and 6 SEHPs also use measures specific to children, such as childhood immunizations, well-child visits, appropriate treatment of children with upper respiratory infections, and lead screening.

- Oklahoma produces HEDIS measures, emergency room (ER) utilization, primary care provider and case management (PCP/CM) profiles, encounter validation and other utilization studies. Oklahoma anticipated distributing EPSDT and breast and cervical cancer screening rate provider profiles in January 2007. The SoonerPsych program tracks prescribing patterns for behavioral health medication regimens and educates outlying prescribers about best practices for these regimens. In addition, an electronic prescribing pilot program should alert prescribers when patients are prescribed multiple drugs that may be duplicative, contraindicated, or potentially problematic; it will also track trends based on best-practice guidelines and notify and educate outlying prescribers.

Patient safety contract requirements are less common

Of the 30 Medicaid agencies and 14 state employee health plans that contract for primary care management, few require reporting on patient safety measures, such as adverse drug events or administering antibiotics prior to surgery to prevent post-operative infections. Four Medicaid agencies (District of Columbia, Florida, Nebraska, Oregon) and three SEHPs (Maine, Washington, Wisconsin) require reporting on patient safety measures on all contracts and an additional three Medicaid agencies (California, Iowa, Massachusetts) and one SEHP (Minnesota) require such reporting on some contracts. No freestanding SCHIP contracts require such reporting. This response seems to support results from a recent survey that found only eight Medicaid programs currently have hospital inpatient measures for any combination of patient safety, process, serious reportable events, or infrastructure/structure measures included in their quality monitoring activities.¹⁰⁵

All respondents use nationally developed patient safety measurement sets

As with quality, all Medicaid and SEHPs that require patient safety reporting in their contracts use national patient safety measures; most also use state measures (Connecticut Florida, Massachusetts, and Oklahoma Medicaid agencies; Maine and Minnesota SEHPs). Most also have patient safety measures specific to children (California, Connecticut, District of Columbia, Nebraska, Oklahoma Medicaid and Maine, Minnesota). However, some referenced HEDIS measures on immunizations and EPSDT, which might be better categorized as quality rather than patient safety.

- Iowa Medicaid requires HEDIS measures and sentinel event reporting in some contracts
- Massachusetts Medicaid requires behavioral health critical incident reports.
- The state of Oregon requires health plans to require contracted hospitals to report adverse events to the Oregon Patient Safety Commission.

Most agencies take quality performance into account for at least some contracting

Twenty-four states take quality performance into account for at least some contracting, including 18 Medicaid agencies, 3 separate SCHIP programs, and 9 state employee health plans. The majority of agencies (15) do so through quality review points. Only one agency, the Nebraska Medicaid agency, uses selective contracting for quality.

- The Wisconsin state employee health plan provides financial rewards for excellent HEDIS scores and public reporting of HEDIS and CAHPs.
- Several states mentioned that they require health plans to be accredited by the National Committee for Quality Assurance (NCQA) to indicate that systems are in place to assure that enrollees receive good quality care.

Medicaid agencies are most likely to provide incentives and disincentives that reward performance

Twenty-six states provide contract or plan incentives to reward performance; the most common mechanism that agencies use is pay-for-performance (15). Seven agencies use preferential auto-assignment, which rewards contractor performance by providing a greater volume of patients. Only one, the Texas Medicaid and SCHIP agency, reports using gain-sharing. Incentives are much more common among Medicaid agencies (22) than state employee health plans (Indiana, Maine, Minnesota, Ohio, Wisconsin). States most often mentioned well-child care as the type of contract service that includes incentives.

- New York uses HEDIS performance as a factor in auto-assignment. Arizona uses an auto-assignment algorithm adjusted to favor high performing plans.
- Oklahoma provides an EPSDT bonus payment for providers with screening at or better than 65 percent. An immunization incentive is paid for each child immunized with the fourth DTaP vaccine before the age of two.

- Washington State Medicaid provides a separate incentive payment for performance on immunization and well-child measures. Pay for performance incentives for immunization of 2-year-olds and well-child care have been part of the Healthy Options/SCHIP contract since 2004. Calculations are based on a point system that rewards health plans for both their current year performance relative to other plans and for their improvement from previous year to current year relative to other plans. The four highest performing plans share in the reward.
- The Massachusetts state employee health plan mandates participation in a clinical improvement initiative.
- Three Medicaid programs (Arkansas, Massachusetts, and Pennsylvania) have recently developed initiatives to improve the quality of hospital inpatient care. Of these, Arkansas and Pennsylvania launched a hospital pay-for-performance (P4P) initiative in 2006. Nineteen Medicaid programs have a P4P initiative in outpatient care.¹⁰⁶

Twenty states provide disincentives for poor performance in at least some contracts. They do so through withholds (8) and penalties (12), but even more commonly through other means (14). Disincentives are much more common among Medicaid agencies (17) than state employee health plans (Massachusetts, Minnesota, and Ohio). Types of contracts mentioned included PCCM and behavioral health.

- Michigan and Missouri Medicaid agencies mentioned freezing or limiting auto assignments. Michigan also can freeze or limit all enrollments and Missouri can make capitation rate adjustments.
- Oklahoma Medicaid can recoup and/or withhold a portion of the provider's capitation payment, and freeze or permanently reduce a provider's maximum panel size.
- Alabama Medicaid can reduce case management fee components if contract requirements are not met.
- Ohio's state employee health plan can issue financial penalties for not meeting benchmarks.

Fewer states take patient safety performance into account when contracting

Ten states take patient safety performance into account when contracting, including five Medicaid agencies (Idaho, Massachusetts, Nebraska, Oklahoma, Oregon) and six state employee health plans (Maine, Minnesota, Oregon, South Carolina, Washington, Wisconsin). They do so through patient safety review points (Maine, Oregon) and selective contracting for patient safety (Maine, Nebraska, Washington).

- The Maine state employee health plan introduced a tiered hospital benefit in 2006 in order to improve hospital patient safety and quality performance. All Maine acute care hospitals were rated on three measurement categories: patient safety as defined by the Leapfrog Group safe practices survey, results of the Maine Health Management Coalition's (MHMC) medication safety survey, and the average aggregate performance on CMS clinical measures for heart attack, heart failure, and pneumonia. Members were provided an incentive to seek care from selected "preferred" hospitals. If a member

received care from a preferred hospital, any of the charges billed by that hospital would be exempt from the deductible. Based upon performance on the 2005 surveys and CMS measures, only 15 of 36 hospitals were identified as "preferred." Preliminary data for 2007 indicates that the number of preferred hospitals will likely double, since 35 of the 36 hospitals completed the 2006 Leapfrog and MHMC surveys.

Figure 8 State agencies that take quality and patient safety into account in contracting

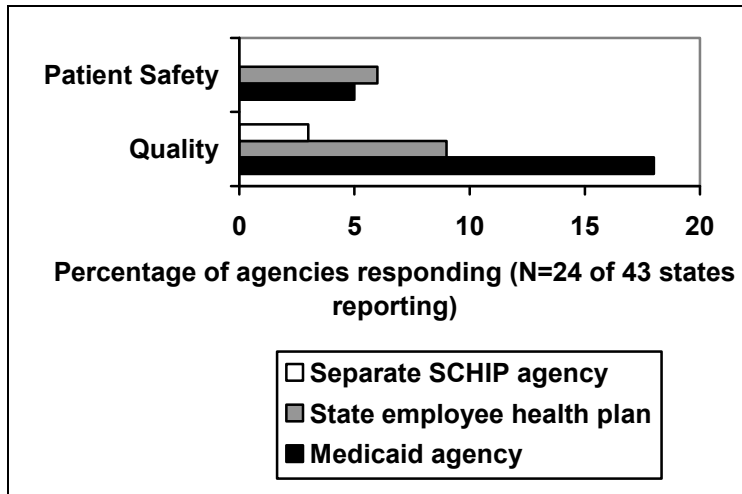


Table 6 State agencies that take quality and patient safety into account for contracting

State	Contract consideration					
	Quality			Patient safety		
	Medicaid agency	Separate SCHIP agency	State employee health plan	Medicaid agency	Separate SCHIP agency	State employee health plan
Arizona	•					
California	•					
Connecticut	•	•				
Georgia	•					
Idaho	•			•		
Indiana	•					
Louisiana			•			
Maine			•			•
Massachusetts	•		•	•		
Michigan	•					
Minnesota			•			•
Nebraska	•			•		
Nevada	•					
New Jersey	•					
New York	•					
Ohio	•		•			
Oklahoma	•			•		
Oregon			•	•		•
Pennsylvania		•				
South Carolina	•		•			•
Tennessee	•					
Texas	•	•				
Washington			•			•
Wisconsin	•		•			•
Total (n=24 out of 43 states reporting)	18	3	9	5	0	6

Most agencies include in their contracts care management for specific populations, most frequently for chronic illness

Agencies in 34 states include in their contracts formal care management services or programs for special needs, most frequently for chronic illness (27) and pregnancy (19). These commonly include disease management for asthma and diabetes; other conditions such as HIV/AIDS, congestive heart failure, cancer, chronic pain, and lower back pain were also mentioned. Care management for out-of-home placement only occurs in three Medicaid programs (Massachusetts, Nebraska, and New Mexico).

- Ohio Medicaid includes services for children and families: asthma and HIV/AIDS (children over 21), hypertension, diabetes, severe substance abuse and cognitive/developmental limitations.
- Georgia Medicaid requires care management for infants and toddlers with established risk for developmental delay and lead case management for EPSDT eligibles and their households when there is a positive blood test for lead equal to or greater than 10 micrograms per deciliter.

Leveraging purchasing power through contract requirements: stressing quality through contracting in Minnesota

Minnesota's QCare (Quality Care and Rewarding Excellence) 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 of 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 to be provided to all patients presenting with a heart attack, heart failure, and pneumonia. Hospitals in the top 20 percent of performers will receive payment incentives; after 3 years, hospitals that fall below minimal benchmarks will face penalties. Provider performance on all of these measures will be publicly reported on 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 website, <http://www.health.state.mn.us/healthinfo/qcare.html>, and the Governor's Health Cabinet website, <http://www.thehealthcabinet.com/QCare.htm>.

- The Oklahoma Medicaid Care Management Department manages children receiving private duty nursing in the home, transplant candidates and recipients, women enrolled in the Breast and Cervical Cancer Treatment Program, children with certain disabilities, members identified for second-tier referrals for emergency room utilization, and members with medically complex and special health care needs, such as high-risk obstetrics and those with dual diagnoses.

Medicaid and SCHIP agencies are most likely to address race, ethnicity, language, disability, and special needs

Medicaid and SCHIP contracts are more likely to include specifications that address identifying populations by race, ethnicity, or language than state employee health plans. Only the Massachusetts state employee health plan does so for some contracts, whereas 18 Medicaid agencies and 4 SCHIP agencies do so.

- Massachusetts Medicaid must provide race and ethnicity information of members to the MCOs so that contractors can better serve the cultural and linguistic needs of members.
- Nevada’s MCOs identify the race, ethnicity, and primary language spoken of each enrolled recipient to gather baseline data. This data may lead to the development of a Performance Improvement Project (PIP).

Many Medicaid and SCHIP contracts include specifications that address identifying populations by disability or special need (24 and 4, respectively) in order to better meet their needs. Many agencies mentioned children with special needs as a specific population; other populations included those with HIV/AIDS, the homeless, and people with mental health needs. No state employee health plans do so.

- Michigan Medicaid defines persons with special health care needs as those individuals enrolled in the Children with Special Health Care Services program who age out of the program (age 21) and become eligible for enrollment into health plans. The purpose is to provide a smooth transition between programs.
- The Texas SCHIP agency requires HMOs to develop and maintain a system and procedures for identifying members with special health care needs, including people with disabilities or chronic or complex medical and behavioral health conditions and children with special health care needs. MCOs are responsible for providing service management to ensure access to treatment by a multidisciplinary team when the member's primary care provider determines the treatment is medically necessary, or to avoid separate and fragmented evaluations and service plans.

Many state agencies include contract specifications for communications capabilities for serving individuals with disabilities; this is the case for 24 Medicaid, 4 SCHIP, and 3 state employee health plans. Populations mentioned include SSI-related diagnoses and medically-fragile foster care children. Contract specifications for cultural competency exist for 24 Medicaid, 3 SCHIP, and 1 state employee health plan.

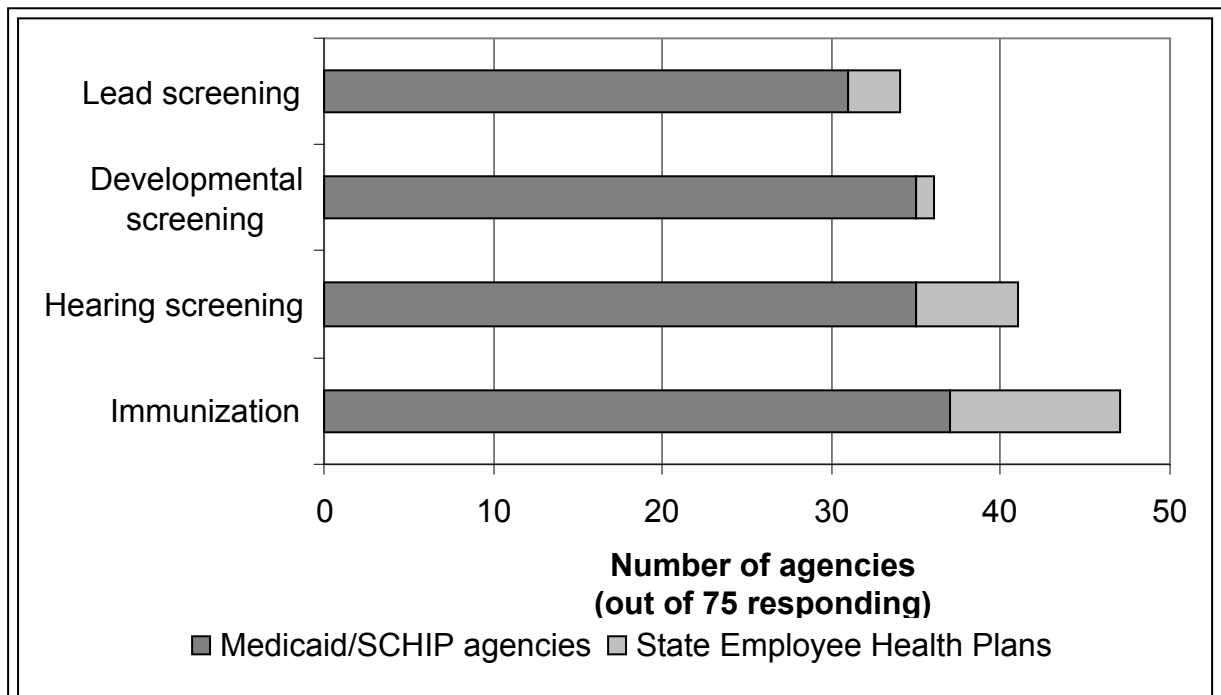
Most Medicaid and SCHIP agencies define a well child pediatric standard of medical necessity and specifically require certain preventive components

Most Medicaid and SCHIP (29) agency contracts define a pediatric standard of medical necessity – one that addresses maintenance of health and promotion of growth and development – in at least some of their contracts; only Maine and Ohio state employee health plans do so.¹⁰⁷ As expected, contracts to serve seniors do not include such language.

Medicaid and SCHIP contracts are more likely than state employee health plans to specifically require the following preventive services that are components of EPSDT:

- Lead screening requirements (31 Medicaid/SCHIP agencies, 3 state employee health plans – Maine, New York, Minnesota).
- Developmental screening requirements (35 Medicaid/SCHIP agencies, 1 state employee health plan – New York).
- Hearing screening requirements (35 Medicaid/SCHIP agencies, 6 state employee health plans – Maine, Massachusetts, Minnesota, New York, North Dakota, Tennessee).
- Immunization requirements (37 Medicaid/SCHIP agencies, 10 state employee health plans¹⁰⁸).

Figure 9 Agencies reporting purchasing requirements for children’s preventive services



Among the examples:

- California Medicaid managed care plans are contractually required to follow the Advisory Committee on Immunization Practices and Centers for Disease Control guidelines; the California Code of Regulations for lead screening; American Academy of Pediatrics guidelines on hearing screening; and to identify members and refer to regional centers or local early start programs for developmental issues.
- The Minnesota state employee health plan offers, but does not require, immunizations, lead screening, and hearing screenings.

Most state agencies do not recommend or require specific developmental screening tools in their contracts

There is clear evidence in the literature that primary care providers who use an objective developmental screening tool do a better job of identifying children with potential developmental delays than do primary care providers who rely only on clinical judgment.¹⁰⁹ Medicaid and other state agencies can play an important role in promoting system and practice level change to improve routine identification of young children with developmental problems.

According to the survey results, state agencies are far less likely to recommend or require use of specific developmental screening tools in their contracts; only 12 Medicaid or SCHIP agencies do so.¹¹⁰ No state employee health plans do so.

- The Louisiana Medicaid agency recommends the Ages and Stages Questionnaires® (ASQ); BRIGANCE® Screens; Child Development Chart (CDC); Denver Developmental Screening Test II (Denver II); Parents Evaluation of Development Status (PEDS); and Prescreening Developmental Questionnaire (PDQ II).
- The Massachusetts Medicaid agency lists recommended developmental and behavioral screening tools, including but not limited to the Denver Prescreening Developmental Questionnaire, Denver Developmental Screening Test II, Early Language Milestone Scale, Ages and Stages Questionnaire®, BRIGANCE® screens, Child Development Inventories, Parents Evaluation of Developmental Status (PEDS), and Pediatric Symptom Checklist (PSC).
- The Minnesota Medicaid contract offers incentive payments for increases in developmental and child mental health screenings above the prior calendar year level reported by the MCO. It is also one of the determinants for the MCO to regain withheld capitation payments.

Joint Purchasing

NASHP surveyed Medicaid, SCHIP, state employee health, and public health agencies about joint or coordinated purchasing strategies with other agencies/programs, with other states, and with the private sector. Agencies in 48 states responded to this component of the survey,

including 35 Medicaid, 25 public health, 23 separate SCHIP, and 17 state employee health agencies.

Many state agencies have contracts or grant requirements specifically designed to support the goals of other state agencies or programs

Twenty-nine states reported that a state agency has a contract or grant requirement specifically designed to support the goals of another state agency or program; this is most frequently the case for Medicaid (13) and separate SCHIP programs (12), and less frequent in public health agencies (8) and state employee health plans (5).

Two public health agencies (Florida, Massachusetts) and six separate SCHIP agencies (Colorado, Georgia, Maine, Massachusetts, Nevada, Washington) fund only providers that contract with Medicaid. An additional SCHIP program (Kentucky) and two additional public health agencies (Delaware, Florida) fund only providers that contract with other agencies. Fourteen state agencies,¹¹¹ half of which are Medicaid agencies, require use of standards of another agency. Four states use more than one of the strategies mentioned above. Examples of required standards are in the areas of newborn screening, services for children in state custody, and state professional board standards.

- Washington State Medicaid conducts joint drug benefit design and purchasing with the Washington Department of Labor and Industry, Health Care Authority, and the Washington Department of Social and Health Services. The Washington Medicaid program is beginning a joint health technology assessment program with the Washington Health Care Authority and jointly supports the Washington Department of Health's Child Profile health promotional materials and immunization registry.
- Massachusetts Medicaid and public health agencies follow guidelines of the Massachusetts Health Quality Partnership.
- In South Carolina, the departments of corrections and juvenile justice piggy-back onto state health plan hospital contract reimbursement rates for inmate health care.
- The Oklahoma Medicaid program's immunization incentive program supports the immunization goals of the Oklahoma State Department of Health. PCCM/EPSTD requirements support the immunization goals and Healthy People 2010 initiative of the health department.

State agencies commonly participate in joint requests for proposals

State agencies commonly participate in joint requests for proposals (RFPs) for health care services or products with other state agencies/programs; 25 states report such activity. Medicaid agencies are most likely to do so (12), with separate SCHIP programs (8), public health agencies (3), and state employee health plans (2) less likely. Six states (Connecticut, Maine, Massachusetts, Oklahoma, Texas, and Washington) reported RFPs developed among more than two agencies.

Joint RFPs often address quality but not patient safety

Joint RFPs are much more likely to address quality (17) than patient safety (7). The seven states that address patient safety in joint RFPs (Alaska, Georgia, Maine, Massachusetts, Nebraska, Oklahoma, and Washington) also address quality. Of states that do address quality and patient safety in RFPs, they are almost equally likely to do so through requirements to collect and report quality and patient safety measures (14, 5 respectively) and requirements for quality and patient safety improvement plans or processes (15, 4 respectively). A number of states mentioned behavioral health partnerships as examples (Connecticut, Massachusetts, Michigan, Nebraska, and Oklahoma).

- Massachusetts Departments of Mental Health, Mental Retardation, Elder Affairs, and Children's Trust Fund participate in a joint RFP for outreach services, prevention and education programs, services for substance abuse and mental health in courts, and oral health services for the developmentally disabled. Quality outcome measures are required, as are behavioral health critical incident reports.
- The Maine state employee health plan participates in a joint RFP with the Public Purchasers Steering Group that includes the University of Maine System, Maine Municipal Employees Health Trust, the Maine Education Association Benefits Trust, the City of Portland, and others. The RFP covers prescription drugs, care management services, and medical benefits. The RFP requires providers to collect and report quality and patient safety measures and quality and patient safety improvement plans or processes.
- The Washington Medicaid and state employee health plan agencies have participated in joint RFPs that require collection and reporting of patient safety and quality data. They share quality data or research with the Puget Sound Health Alliance to achieve more value in purchasing. The Washington State Department of Health and state employee health plan have set up mutual managed care contracts.

Joint RFPs between states tend not to address quality or patient safety

Fifteen states¹¹² reported that a state agency has participated in a joint request for proposals (RFPs) for health care services or products with other states; of these, the majority (9) are public health agencies. Many state agencies reported multi-state prescription drug purchasing.¹¹³ Other joint RFPs or grants included vaccines and newborn screening programs.

- Only the Massachusetts public health agency reported that its RFP, grant, or contract requirement addresses patient safety.
- Five states reported addressing quality in joint RFPs, grants, or contracts (Arizona, Connecticut, Massachusetts, Ohio, and Wyoming). Of these, four require collection and reporting of quality measures and three require quality improvement plans or processes.

Table 7 State agencies that address quality and patient safety in joint RFPs

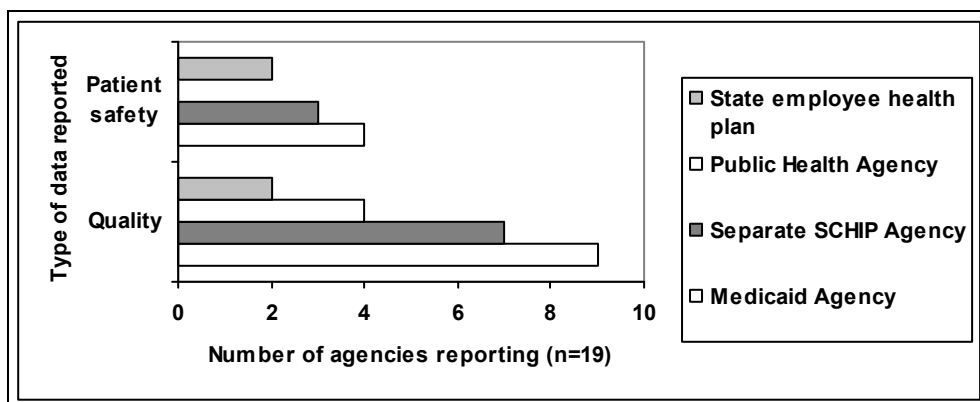
State	Quality				Patient Safety			
	Medicaid agency	Separate SCHIP agency	State employee health plan	Public health agency	Medicaid agency	Separate SCHIP agency	State employee health plan	Public health agency
Alaska	•				•			
Arizona	•							
Connecticut	•							
Georgia		•				•		
Illinois		•						
Iowa	•							
Maine			•	•			•	
Massachusetts	•	•		•	•	•		
Michigan	•							
Nebraska	•				•			
Nevada		•						
New Mexico				•				
New Hampshire		•						
Oklahoma	•				•			
Texas	•	•						
Washington		•	•			•	•	
Wyoming				•				
Total (n=17 of 48 responding)	9	7	2	4	4	3	2	0

State agencies more commonly share price data than quality and patient safety data for value purchasing

States agencies are almost equally likely to share or pool cost or price data or research (19) as quality data or research (17). They are less likely to share or pool patient safety (7) data or research. Many respondents qualified that the data sharing arrangement is not necessarily aimed at achieving more value in purchasing.

- The California public health agency shares data from its perinatal outcomes project with academic researchers and Medicaid staff.
- The Maine Health Management Coalition publicly shared the results of a hospital medication safety survey, clinical outcomes data for primary care practices, and hospital payment information. Members of the Public Purchasers Steering Group also share aggregate expenditure data.

Figure 10 Agencies reporting quality and patient safety data



- The Illinois Medicaid program shares data with the public health agency to track, monitor, and improve child health outcomes, and the public health agency shares data with the Medicaid agency to get a more accurate reflection of true rates for immunizations and lead screenings.
- The Nevada public health agency compiles a Nevada HMO Quality Indicator Report and Sentinel Events Registry.

Intra-state data sharing is not as common as inter-state sharing among multiple state agencies. Nevertheless, the same trend is evident; states are much more likely to share or pool cost or price data or research (7) or quality data or research (7) rather than patient safety (2) data or research. Several states mentioned sharing data on their Web sites.

- Connecticut has shared adverse event data with Minnesota.
- Missouri and Utah have a federally-funded joint patient safety project.

Public/private health care purchasing initiatives do not often address quality or patient safety

Seventeen states report participation in public/private health care purchasing initiatives. Of these, nine states¹¹⁴ reported that joint RFPs, grant, or contract requirements address quality; almost all nine states do so through requirements to collect and report quality measures and quality improvement plans or processes. Massachusetts, Minnesota, and Oklahoma use other means. States are not as likely to report joint RFPs, grant, or contract requirements that address patient safety. Only three states (Florida, Maine, and Rhode Island) do so; in all three cases, they addressed patient safety through requirements to collect and report patient safety measures. Only Maine also required patient safety improvement plans or processes.

- Ten to fifteen percent of county health departments in Florida contract with external providers for personal health services. They are required to collect and report quality and patient safety measures.

- The Maine state employee plan participates in an ad hoc group that includes five large purchasers from both the public and private sector. This group has agreed to a set of purchasing principles and RFP language related to patient safety and quality performance. Although purchasing is conducted separately by each entity, the group has agreed to common requirements, including performance measures endorsed by the Maine Health Management Coalition. This partnership enables these purchasers to influence the market in a manner that does not disrupt the unique environments confronting each organization. This same group has also used a dialogue with providers and health plans to leverage changes in reimbursement methods.
- The Washington state employee plan participates in the Puget Sound Health Alliance, a regional partnership involving employers, physicians, hospitals, patients, health plans, and others working together to improve quality and efficiency while reducing the rate of health care cost increases across five counties in Washington State. Alliance participants agree to use evidence to identify and measure quality health care, then produce publicly-available comparison reports designed to help improve health care decision-making.
- The Wisconsin state employee plan participates in a public/private initiative to purchase pharmacy benefit management services. The initiative requires collection and reporting of quality measures and quality improvement plans or processes.

□ □ □

HEALTH SYSTEMS INFRASTRUCTURE

Introduction

Previous sections of this report focused on aspects of state health policy and practice that promote equitable access to high quality and efficient care. In this section, we turn our attention to state roles in select areas that support system performance by assuring that key system supports – or infrastructure – are in place. The system capacities that were 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 and exchange; and
- population based approaches to improving health outcomes.

This latter capacity is an essential complement to health care in assuring that the overarching goal of a high performance health system – long, healthy, and productive lives – is achieved.

While state government generally has some role in each of these aspects of systems infrastructure, the extent of that role varies, as does the role relative to the private sector and to federal and local partners. Working closely with federal and local partners, state governments, and particularly state public health agencies, have a long history and a strong leadership role in monitoring and seeking to improve the health outcomes of populations within states. The degree of collaboration and integration of population based public health approaches with personal health care systems, however, is more variable. The SHAPES study includes a focus on this relationship, as well as on select public health policies, because both population based and personal health care systems are necessary to achieve desired health outcomes.

State roles in assuring access to providers, especially for vulnerable populations, tend to vary significantly across states. This is an area of policy where there are strong federal and community roles, with the latter including public and private nonprofit entities. This study examined some of the ways in which state government is engaged in addressing access to providers for vulnerable and underserved populations, working with the federal and community levels.

The other area of infrastructure examined for this report focuses on state practices in regard to key data and information systems. States' public health systems have long had a strong role in collecting and analyzing data to monitor and diagnose various health conditions on a population basis. Our survey included a focus on the extent to which states are integrating what historically were stand-alone data systems to create a more comprehensive population health data system accessible to a range of users. We also turned our attention to a newer but critical area of policy and practice – health information exchange and technology. Here, the private health sector and the federal government have played strong roles in developing new technologies and addressing their application to health systems. We examined the evolving role of state government in this

arena, which many see as essential to achieving system innovation and improvement, a key attribute of a high performance health system.

Assuring Access to Providers, Especially for Underserved Populations

States carry out a number of roles in efforts to assure that there are sufficient well-qualified providers available and appropriately placed to assure equitable access to systems of care. States play roles in 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 increasingly, providing information to help consumers find and select providers. As in many other areas of health policy, state governments also often assume special responsibilities in assuring availability of providers for vulnerable and underserved populations, an area in which the federal government and communities play a strong role. These populations may include those living in inner city and rural areas without sufficient providers; low-income, uninsured, and underinsured populations; children and youth; and individuals with chronic illnesses and disabilities. States' traditional roles in promoting access to care now are being supplemented or retooled by the availability of new technology.

This study selected three areas to explore in regard to policies and practices that promote equitable access to providers, and thus contribute to high performance health systems. These are: monitoring the status of the health care safety net, addressing health professions shortages, and providing for electronic clinical consultations.

Many states are monitoring the health care safety net

In the 2000 edition of *America's Health Care Safety Net: Intact but Endangered*, the Institute of Medicine (IOM) found:

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, geographic variation has made data tracking more difficult. Important data are often missing or inadequate. Given these circumstances, 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.¹¹⁵

Although the accompanying recommendation suggested a national monitoring effort, our study examines the extent to which states are engaged in monitoring the safety net consistent with this IOM recommendation. The State Health Access Data Assistance Center (SHADAC) has concluded that *“the development of the safety net, which has occurred in a piecemeal fashion in local communities based on different needs and environmental support, does not lend itself to an easy data collection scheme. We recommend that the state be an organizing entity, that national efforts begin with key indicators that are easily quantified and collected, and that in any national*

scheme, state and local community variation be acknowledged through an ongoing case study approach.”¹¹⁶

Based on the specific recommendations of the Institute of Medicine, public health agencies were asked if and how their states were monitoring the status of the safety net of providers which deliver a significant level of health care to uninsured, Medicaid, and other vulnerable populations. Sixty percent – 15 of the 25 public health agencies which responded – indicated that the state was carrying out some activities to monitor the status of the safety net, as depicted in Table 8.

Although in most of these states (11 of 15) the state public health agency is conducting the monitoring, some other state agencies such as umbrella human service agencies also were reported to be conducting monitoring. A number of states also cited roles and collaborative

Table 8 States monitoring the status of safety net providers

State	Tracking and analyzing the effects of changes in major safety net funding programs	Using existing data systems to assess the status of the safety net	Using existing data systems to assess health outcomes for vulnerable populations relying on the safety net	Collecting new information to monitor the status of the safety net	Informing federal, state, or local policy makers about the status of safety net systems and providers	Identifying and disseminating best practices
California	•	•				
Florida	•		•	•	•	
Idaho						
Maine				•		
Massachusetts		•				•
Missouri		•	•	•		
Montana						
New Mexico		•	•			
North Carolina	•	•			•	
Ohio						•
Oklahoma	•	•	•	•	•	•
Rhode Island	•	•	•		•	•
Utah	•	•			•	
Virginia				•		•
West Virginia	•	•			•	
Total (15 of 25 public health agencies responding)	7	9	5	5	6	5

relationships with other entities, including primary care associations representing community health centers (mentioned by four states). A number of states reported actions resulting from monitoring.

- West Virginia reports that its data show the number of uninsured Medicare and Medicaid patients served, trends, and areas of unmet need. Data also identify safety net providers that may be at financial risk and allow for projections and planning for additional services in underserved areas.
- Maine’s CDC has worked in conjunction with the Maine Primary Care Association and individual providers to develop applications for Federally Qualified Health Center (FQHC) status and to support efforts to increase access.
- Florida reports a low-income pool for financing access to services for the uninsured and that the state has developed a team to monitor Medicaid modernization efforts, provide feedback, and plan for the future.
- North Carolina reports increased state funding for the safety net to serve low income uninsured populations.

Safety net monitoring and surveillance: 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 have primarily used Medicaid payments to Federally Qualified Health Centers to track how patients utilize primary care, dental, and mental health services. Their preliminary findings indicate that patients frequently cross county boundaries to access all of 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 the county where the service was provided, and not on 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 difficulties, and refine its picture of health care safety net use in the state.

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

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

States are addressing shortages in health professions through a mix of strategies

This study also examined ways that states are addressing critical shortages in health professionals that affect provider capacity in health systems. While such shortages can affect

access to care for many, they can have particularly deleterious impact on those without the resources to travel long distances, pay higher rates, or otherwise face barriers to care.

A 2006 article in the *Journal of the American Medical Association* underscores the severity of the problem as it affects community health centers. “Shortages of Medical Personnel at Community Health Centers: Implications for Planned Expansion,” found that a physician shortage threatens the success of recent federal initiatives to expand the number of health centers in the nation.

The study reported that health centers have more than 400 vacant positions for family physicians, the physician specialty upon which the centers depend the most. The number of unfilled positions is particularly high in rural areas. The problem may worsen because of recent cuts in federal funding for training family physicians, and recent declines in the number of medical students choosing family medicine or other primary-care fields such as internal medicine or pediatrics. Health centers also have considerable difficulty recruiting obstetricians, psychiatrists, and dentists. More than 25 percent of the funded positions for these three disciplines are unfilled in the nation’s rural Community Health Centers.

The study also found that health centers are highly dependent on federal programs such as the National Health Service Corp. (NHSC), as well as state programs that re-pay educational loans for physicians who choose to work in medically underserved settings.¹¹⁷ Centers also rely on state loan repayment programs to help hire dentists; 23 states have such programs for dentists and other health professionals who serve in health centers or other public settings.¹¹⁸

This study examined three types of strategies that states can utilize to address health professions shortages. These are: state funding for scholarship or loan repayment programs; waivers to allow foreign medical graduates to practice; and state policies or plans to expand the use of a range of providers, beyond those with doctorates in medicine, psychiatry, dentistry, or other areas. A sizeable majority of the 25 public health agencies responding to the survey reported employing the first two strategies – 22 and 20 states respectively, as shown in Table 9.

About a third of responding states (eight) reported policies and plans to expand the use and scope of practice of non-physician or dentist providers.

Figure 11 Strategies reported by public health agencies to address health professions shortages

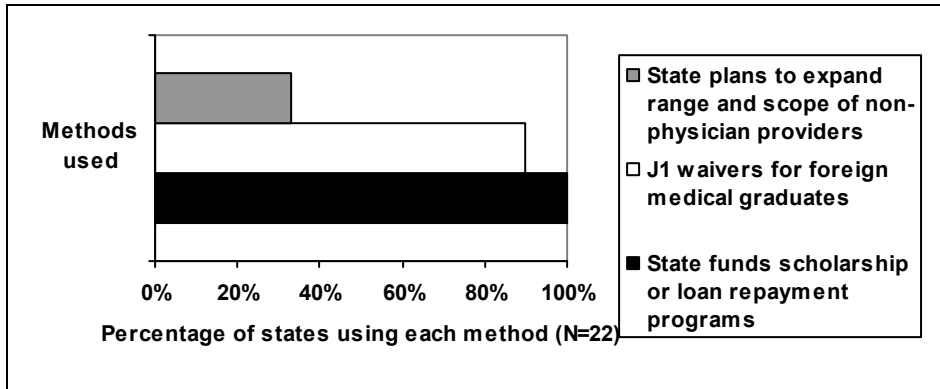
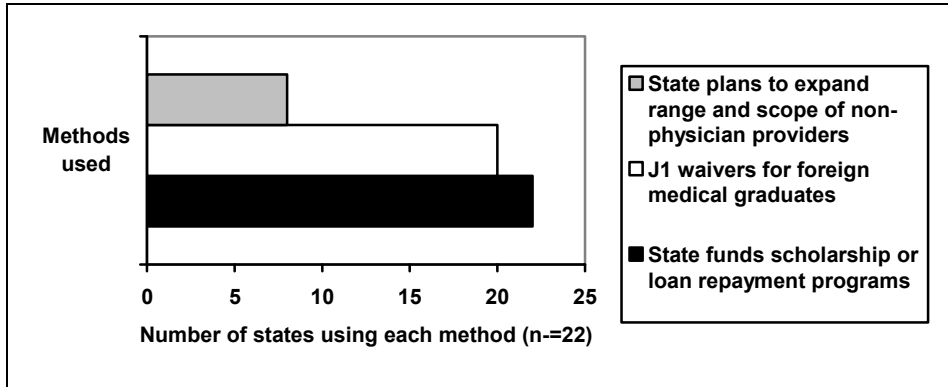


Figure 12 Type of service providers addressed in plans/policies to address range/scope

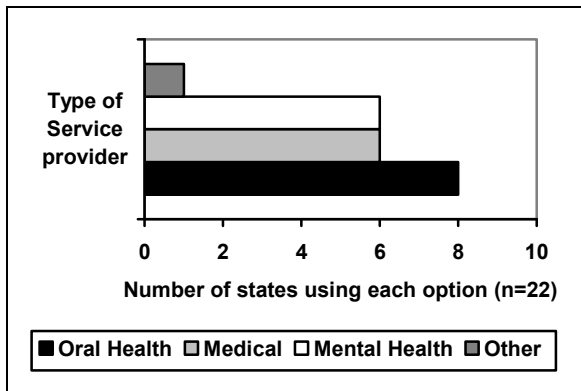


Table 9 Strategies used by public health agencies to address health professions shortages

State	State funding for scholarship or loan repayment programs	J1 waivers for foreign medical graduates	State plans/policies to expand range of providers/use and scope of practice of non-physician providers	Type of service providers addressed in plans/policies to address range/scope			
				Medical	Mental health	Oral health	Other (specified here)
Alabama	•	•					
California	•	•					
Connecticut	•	•				•	
Delaware	•	•					
Florida	•	•	•	•	•	•	• (AHECs)
Idaho	•	•	•	•	•	•	
Kentucky	•	•					
Maine	•	•					
Massachusetts	•	•	•	•	•		
Mississippi	•	•					
Missouri	•	•	•	•			
Montana	•	•					
New Mexico	•	•	•	•	•	•	
North Carolina	•	•	•		•	•	
Ohio	•	•		•	•	•	
Oklahoma	•	•					
Rhode Island	•	•					
Utah	•						
Virginia	•	•	•			•	
West Virginia	•	•					
Wisconsin	•	•	•			•	
Wyoming	•						
Total (22 of 25 responding)	22	20	8	6	6	8	1

Public and Private Coverage of Telehealth Electronic Consultations

One way that states can help residents overcome distance, transportation, and other similar barriers to care is 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.¹¹⁹ Our survey looked at both public and private coverage of telemedicine.

Many states are reimbursing for electronic consultations

In 13 states out of 43 that responded to this part of our survey, the state's Medicaid, SCHIP, or state employee health plan purchases or reimburses for electronic consultations between physicians and patients. In 8 states, the state's Medicaid, SCHIP, or state employee health plan purchases or reimburses for electronic consultations between specialists and primary care physicians. In 6 states, the state's Medicaid, SCHIP, or state employee health plan purchases or reimburses for electronic monitoring of patients from an off-site location. Nine states responded that they provide some other type of public coverage for telemedicine.

- The New York Medicaid program has recently implemented a telemedicine program for physician specialist consultations for emergency room and inpatient care.¹²⁰
- The Utah Medicaid program covers outpatient mental health services, including psychiatric evaluations, physician medication management services, and individual therapy services when provided in a telehealth setting and through a rural community mental health center. Additionally, the following services are covered for Telehealth home health care patients: monitoring for compliance in taking medications, foot condition and assessment of wounds or inflamed areas, blood glucose monitoring education which may include a review in knowledge of the disease process, diet or nutritional counseling, exercise and activity, diet and activity, adjustment in illness or stress, medication, and glucometer use.

Few states require private coverage of electronic consultations

In the private market, very few states that responded to our survey currently require insurers to reimburse for telemedicine. Only 2 states (Minnesota and Hawaii) out of 34 insurance agencies that responded to this part of the survey require 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 or to purchase or reimburse for electronic monitoring of patients from an off-site location. Three states (Colorado, Kentucky, and Minnesota) 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.

Table 10 State use of electronic consultations

State	Electronic consultations between physicians and patients			Electronic consultations between specialists and primary care physicians			Electronic monitoring of patients from an off-site location		
	Medicaid	SCHIP	State employee health plan	Medicaid	SCHIP	State employee health plan	Medicaid	SCHIP	State employee health plan
California	•							•	
Idaho	•								
Iowa	•								
Kentucky		•			•			•	
Minnesota	•			•			•		
Nebraska	•								
New York			•	•		•			
South Carolina	•								
Tennessee	•			•			•		
Texas				•	•				
Utah				•					
Vermont		•			•				
Virginia	•			•			•		
Washington			•						•
Wisconsin	•								
Totals=15 of 43 responding	9	2	2	6	3	1	3	2	1

Supporting Information Systems and Technology

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’s 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.”¹²¹ 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 only begun to command attention.

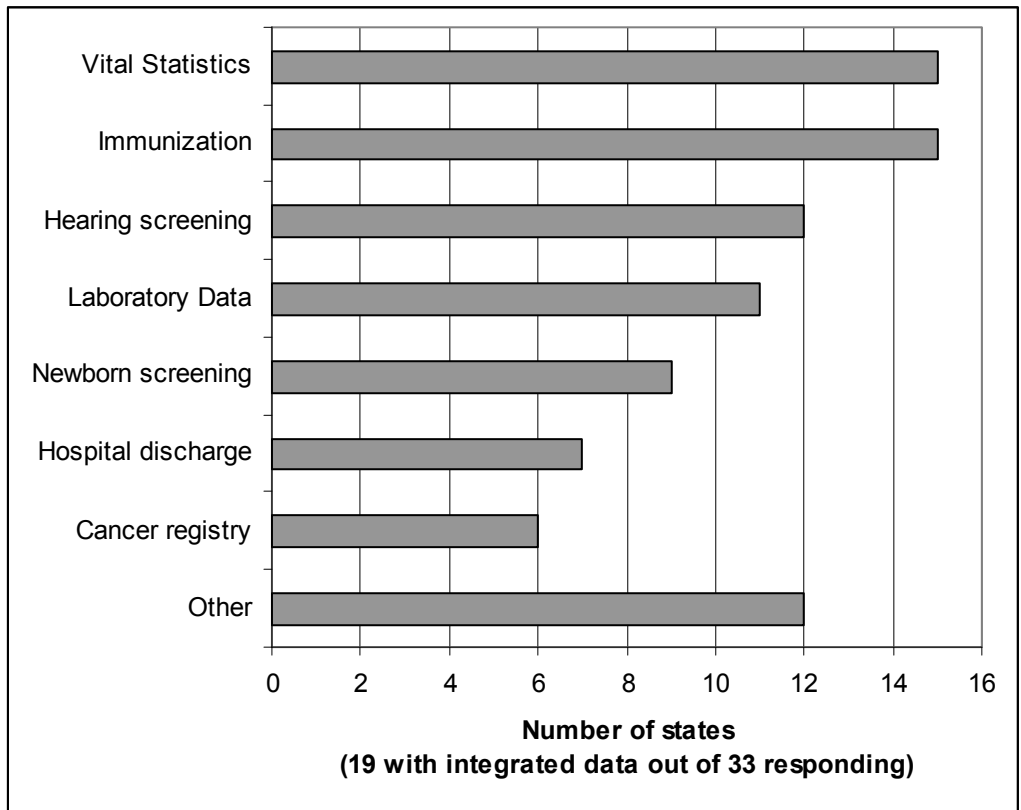
The SHAPES study focused on two particular areas related to information systems, technology, and exchange. First, consistent with the project’s attention to the intersection between population based public health and health care systems approaches, we examined the extent to which states report integrated public health information systems. Next, we addressed the role of states in health information exchange and technology.

Most states have public health information systems that integrate data from multiple sources

More than half of responding public health agencies and governors’ offices (19 of 33) 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 (15 states each), followed by hearing screening (12 states), laboratory data (11 states), newborn screening (9), hospital discharge (7) and cancer registry (6). Other data systems that were mentioned include health surveys and surveillance data, lead screening, maternal and child health service data, and hospital emergency services data.

In all of these states, the primary users of these data systems are public health agency employees, followed closely by employees in other state agencies (14 states), and by private sector health care providers (13 states). Public use was reported by only seven states.

Figure 13 Data reported as included in integrated public health information systems



Integrated public health information in Oklahoma

The Public Health Oklahoma Client Information System (PHOCIS) that Oklahoma is developing is a powerful tool 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 also 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.

An example of the analyses that this coordination of data allows is with the state's SoonerStart program, which provides early interventions for vulnerable infants and toddlers with developmental delays. SoonerStart can use PHOCIS to access Medicaid claims information in order to track a child's immunizations, and then use vital records data to determine whether the intervention has been cost-effective in reducing long-term costs and achieving desired outcomes.

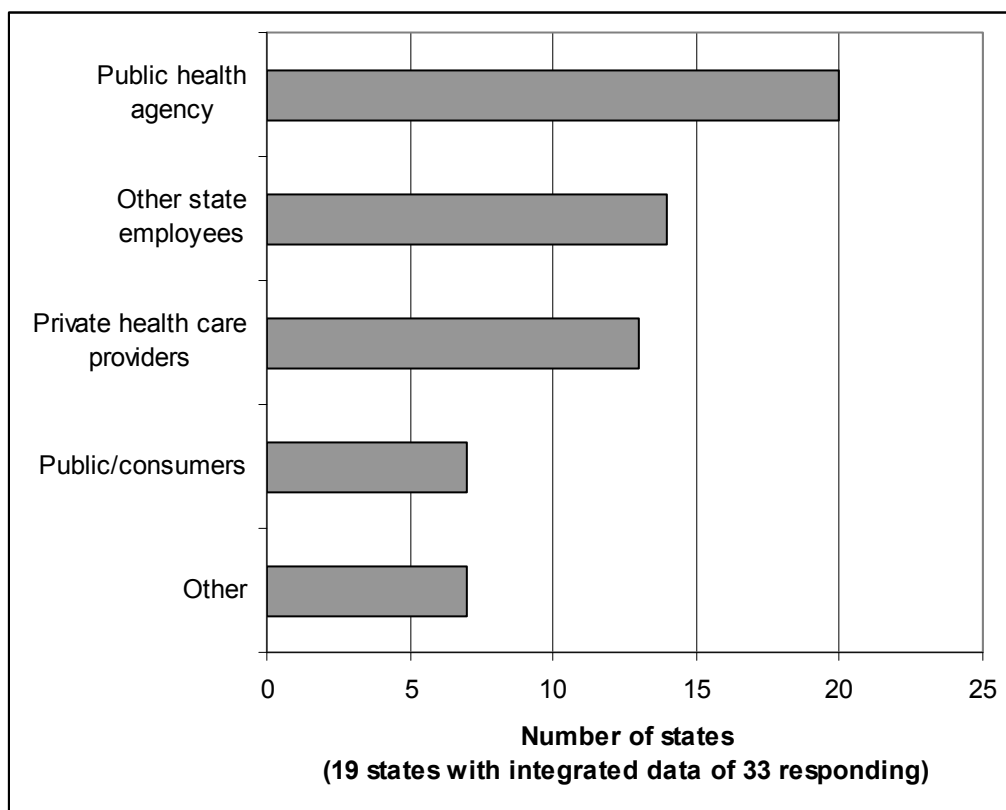
Along with PHOCIS implementation, Oklahoma is also engaged in several related projects to move to electronic health records, and to integrate tribal, private, and public medical records, which will further enhance the state's ability to monitor and analyze its overall health picture.

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>.

Two examples of these systems and their potential follow.

- Maine is developing a particularly ambitious system. “When fully implemented, the Integrated Public Health Information System, or IPHIS, will offer public health practitioners and private providers access to a wealth of health information on the Web. IPHIS allows each public health program to maintain its own database while contributing data to a central data repository. The integrated system will offer immunization registry data, vital records, lab results, health alerts, and other critical information displayed within a unified Web interface via a secure, single sign-on.”¹²²
- The Wyoming Department of Health, as an agency, is building the enterprise core infrastructure that will integrate all internal programs and databases within public health's purview. The prototype is limited to five (5) major databases to start and this effort has already begun. The five databases are: Vital Records, Immunizations, the Wyoming Client Information System (an integrated online mental health and substance abuse information system), and the Best Beginnings and Early Hearing Detection and Intervention Program. This effort is expected to expand to the Department of Family Services in the near future as the first prototype for cross-agency data-sharing. This is the first centralization effort for the Wyoming Department of Health and is in its infancy. A complete overhaul of processes, systems, standards, and policies are occurring now.

Figure 14 Reported users of integrated public health information systems



Health Information Exchange and Technology

States can play a number of roles in developing and advancing health information exchange through the use of health information technology. States can facilitate these efforts by serving as a convener of key stakeholders, and they can develop and revise the legal structure through laws and regulations. While states may not be in position to play a major role in financing health information exchange and technology, they can contribute and leverage financing through supporting demonstration initiatives, encouraging or requiring use of health information exchange and technology in their purchasing roles, and accounting for HIT-related costs in their payment policies. As a provider of health services, states also can incorporate e-health connectivity and health information tools into the daily operation of state health care facilities while also addressing potential public health responsibilities, such as bio-surveillance.

Increasingly states are recognizing their need to fulfill these roles. In July 2006 at least ten governors reportedly had issued executive orders addressing HIT and 22 legislatures had passed HIT-related legislation.¹²³ A 2006 study of community and regional initiatives conducted for the Agency for Healthcare Research and Quality identified 165 health information technology (HIT) initiatives in 49 states and two territories. Further, this survey found that 38 states were involved in either a local or statewide HIT initiative and 21 states were leading efforts to convene

stakeholders.¹²⁴ This survey also showed a significant increase in state activity related to HIT initiatives within the past year.

The SHAPES study asked both public health agencies and governors' offices the same questions about the roles the state is playing in health information exchange (HIE) or technology (HIT) initiatives, if any. We also asked Medicaid agencies about their involvement in efforts related to electronic health records, electronic exchange of health information, and other efforts.

Most states are playing some role in health information exchange or technology initiatives

Twenty-two states reported playing roles in exchange of health information across service settings and in adoption of electronic health or medical records. These states and others reported involvement in other kinds of HIE or HIT efforts, especially to achieve public health purposes. Some examples follow.

- Georgia's Department of Community Health (DCH) has recently established a Health Information Technology and Transparency (HITT) Advisory Board. The Department of Community Health administers Medicaid, Georgia's SCHIP, and the state employee health plan, and the Board includes representation from the Division of Public Health.
- Idaho reported state agency participation in a state legislative interim committee that is developing a plan for a statewide health information system.
- In Louisiana, the adoption of health information technology (HIT) has been a key health care reform objective for several years now. In 2004, a group of Louisiana health IT proponents, led by the Louisiana Department of Health and Hospitals and the Louisiana Medicare Quality Improvement Organization, began a process that parallels the development of the national framework for HIT, which has four major goals: to inform clinical practice, to interconnect clinicians, to personalize care, and to improve overall population health. The Louisiana Department of Health and Hospitals is developing a health information exchange prototype to administer the Hurricane Katrina Health Information Network and Digital Health Information Recovery Project. This effort is funded through a contract with the U.S. Department of Health and Human Services, and is called the Louisiana Health Information Exchange (LaHIE). The primary goal of this project is to support the health information needs of evacuees and the recovery of the Gulf Coast Health Information Infrastructure, including interoperable health records. LaHIE will ultimately build upon and enhance the efforts of other health information technology projects in the state; it is the next step to true health information sharing in Louisiana.
- Montana has a successful Diabetes Care Monitoring System to improve provision of clinical preventive services. This is in place in primary care offices. The state is involved in discussions on how to move to the use of health information technology.
- North Carolina is automating its immunizations registry, electronic disease surveillance system, public health laboratory reports, and its health information system for local public health departments.

- Utah reports use of HIT in its health plan pharmacy database and consumer reports on health care system performance.
- In March 2006 the West Virginia legislature passed a law adding Article 29G to the WV legal code to create the West Virginia Health Information Network. Between April 2006 and October 2006 consultants were to develop the plan for WVHIN. WVHIN must be included in the budget and approved by the State Legislature before the work of building the WVHIN begins.

Reviewing and revising legislation and regulations is the most common state role, and purchasing incentives the least common

Over half of states responding to this section of the SHAPES survey – 23 of 33 – are reviewing and revising legislation or regulations to support HIE or HIT. Twenty states reported that they are participating in Regional Health Information Organizations (RHIOs). Twenty states reported a role in funding, by supporting demonstrations or through other means, such as hiring consultants to develop plans and blueprints for systems development. Only three states – Arkansas, Florida and Wisconsin – reported state roles in purchasing incentives for HIE or HIT initiatives.

Many states are convening agencies and other stakeholders for communication, coordination, and information sharing about HIE/HIT

A majority of states are convening stakeholders and agencies around HIE/HIT. States most frequently cited communication, coordination, and serving as a central information source as the impetus to do so (22 to 19 states). Fewer states (16) reported convening stakeholders to advise agencies about HIE/HIT. Others reported foci for convening were: defining the business case for various sectors; identifying and resolving barriers that impede diffusion of telehealth; developing and refining policy recommendations; and developing a five-year implementation plan.

States most commonly are engaging hospitals, health plans, providers, academic medical centers, and consumers when convening stakeholders

When asked which stakeholders they were convening, 28 states mentioned hospitals, 24 included health plans and 24 included primary care providers. Also mentioned by 20 or more states were academic medical centers (23), consumers (22), and medical specialty providers (21). Less frequently included were laboratories (17), integrated delivery networks (15), nursing homes (11), rehabilitation facilities (9), pharmacies (8), and home health agencies (7). A plethora of other kinds of stakeholders also were reported – business, employers, the technology industry, privacy advocates, state legislators, Medicare Quality Improvement Organizations, foundations, unions, dentists, nurses, long-term care advocates, attorneys, state and local public health officials, the Indian Health Service, state agencies involved in health care delivery, and rural and community health centers.

Table 11 State roles in health information exchange and technology

State	Participating in efforts convened by private sector agencies	Reviewing and revising legislation and/or regulations as needed	Funding: demonstrations	Funding: other	Purchasing incentives
Alabama		•			
Arizona			•		
Arkansas	•	•			•
California	•	•		•	
Colorado					
Connecticut	•	•	•	•	
Delaware	•				
Florida	•	•	•	•	•
Georgia	•			•	
Idaho		•			
Kentucky	•	•	•		
Louisiana	•	•		•	
Maine	•	•		•	
Massachusetts		•			
Mississippi					
Missouri					
Montana	•			•	
Nebraska	•	•			
New Mexico	•	•		•	
North Carolina		•			
North Dakota	•	•	•	•	
Ohio	•	•		•	
Oklahoma	•	•	•		
Oregon	•	•		•	
Pennsylvania	•	•		•	
Rhode Island	•	•	•		
South Dakota		•			
Utah	•	•		•	
Virginia			•		
West Virginia		•		•	
Wisconsin	•	•	•		
Wyoming					•
Totals (n=32 of 33 states responding)	20	23	9	14	3

Information systems and 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 non-profit eHealth Connecticut project was launched in 2006, and has as its priorities the development of tools for:

- 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 mechanisms.
- 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 information technologies, and identified potential challenges such as privacy concerns and the need for buy-in among community health care providers. A follow-up meeting was held in June of 2007, entitled Project Jamboree, which provided a forum for groups and individuals involved in HIE-related activities to come together and share the lessons and challenges of planning and implementing HIE projects throughout Connecticut

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

A majority of state Medicaid agencies are actively involved in health information exchange and technology initiatives

Twenty-seven of the thirty-five Medicaid agencies that responded to a SHAPES study question about health information exchange and technology reported some level of involvement in this area. Nine state Medicaid agencies reported that they are involved in electronic health record initiatives being led by other agencies. Nineteen were developing electronic health record initiatives for Medicaid providers. A number of states mentioned that they were applying for available federal “transformation grant” funding to assist with these initiatives. Examples of state Medicaid agency involvement in electronic health record initiatives follow.

- The District of Columbia is focusing on standard medical record forms for the Early Periodic Screening, Diagnosis and Treatment (EPSDT) program.
- Iowa has made available a Web-based tool to access information from the Medicaid claims database such as diagnosis codes, procedures, and prescriptions. The tool allows a provider to see all of the services for which Medicaid paid for that individual. The state was seeking federal grant funds to allow the claims processing system to be improved so that it can participate in health information exchange.

- Louisiana received federal funding to implement technology components and solutions to enable the exchange of health data and information among healthcare providers throughout Louisiana. The focus of the LA Health Information Exchange (LaHIE) Project is to create a health information exchange not only for everyday use but also for emergencies when populations are displaced to other areas. The agency also promotes the transformation of health care from paper to an electronic format by supporting the Health Information Security and Privacy Collaboration (HISPC). This nationwide project, through a contract with Research Triangle Institute (RTI), assesses and develops plans to address variations in organization-level business policies and state laws affecting privacy and security practices in order to identify and address challenges to HIT interoperability
- Michigan Medicaid was working toward EHR by supporting the Michigan Health Information Network (MiHIN), the Health Information Security and Privacy Collaboration (HISPC), and the Health IT Commission.
- Missouri Medicaid was in the procurement process for a new MMIS contract in which these capabilities are being pursued.
- Montana was working on enhancing its Medicaid web portal to provide physicians, nurse practitioners and other mid-levels, and hospitals with information regarding previous patient services paid through Medicaid. In addition, the agency will be working on providing access to Medicaid clients so they can better manage their health care needs.
- New Jersey had plans underway to have clinical health care data available to providers electronically. Beneficiary eligibility data is available on-line to providers.
- New York State legislation (Health Care Efficiency & Affordability Law - HEAL NY) was implemented in 2005. The intent of this legislation is to provide grant funding to medical practitioners and health care facilities to reimburse them for up to 50 percent of the total cost of developing electronic health record initiatives. In the 2005-2006 state Fiscal Year \$65 million worth of funds will be available with the minimum grant distributed being \$50,000 and maximum grant of \$10 million. While not a specific Medicaid initiative, Medicaid providers can apply for these grant funds.
- Oklahoma's 2006 Medicaid Reform Act (HB2842) requires the agency to study how EHR fits into Medicaid and also requires and provides funding for an E-Prescribing pilot.
- South Carolina Medicaid is working with the Office of Research and Statistics to pilot an EHR program that includes claim level data.
- Blue Cross Blue Shield of Tennessee (BCBS) serves as a managed care contractor for the state's TennCare program. Shared Health is a new company formed by BCBS that provides health care providers with electronic access to patient medical record information. The goal of Shared Health is to reduce duplicate testing, harmful drug interactions, and unnecessary procedures by providing medical care providers with complete and up-to-date medical history information via Community Connection, which is an on-line patient health record. TennCare provides Shared Health with various weekly extracts of enrollee data and managed care encounter data for use in Shared Health.
- Texas Medicaid is developing an electronic health record for the foster care Medicaid population in the state, as part of a larger initiative to implement a comprehensive healthcare model for foster children.

- Virginia was seeking federal grant funds to develop a statewide Medicaid electronic health records system accessible through the internet for all clients served by the agency. If the state is awarded the grant and the system is implemented, Medicaid providers will be able to access patient information, including prescription data, diagnoses, and treatments based on claims and encounter data. The Medicaid agency also will provide whatever assistance is needed for the Governor's Health Information Technology Council, developed in 2006. Additionally, the Virginia General Assembly has passed legislation supporting the development and use of electronic health records.
- Wisconsin also was seeking federal grant funding. One component of the grant application focuses on bringing the benefits of electronic health records to the Medicaid population by determining the most effective ways of assuring that safety-net providers serving a high proportion of the Medicaid population have and use electronic health record systems. This initiative will establish policies, and provide operational and technical support to safety-net clinics and providers which do not currently have health information technology infrastructure or an EHR system to encourage their adoption and use. Implementation of this initiative is contingent on grant funding.

Eleven Medicaid agencies also said they were participating in health information exchange initiatives led by other agencies, and thirteen were developing health information exchange initiatives for services purchased or reimbursed by Medicaid. Examples of these exchange initiatives follow.

- California Governor Schwarzenegger signed Executive Order S-12-06 on July 25, 2006. The executive order establishes the eHealth Action Forum for the purpose of developing a comprehensive state policy agenda for health information technology. The California Department of Health Services (CDHS) is participating in the forum and development of the state policy agenda. In addition, CDHS submitted a Medicaid Transformation Grant Proposal requesting funding to establish a pay-for-performance program.
- Georgia Medicaid was working with the state HITT Advisory Board, and will review its recommendations. The agency also is ensuring that RFPs contain requirements for the electronic exchange of health information.
- Missouri Medicaid was in the procurement process for a new Medicaid Management Information System (MMIS) contract in which these capabilities are being pursued.
- New Hampshire was awaiting word on an application to fund a project as part of the federal Deficit Reduction Act Transition Grant initiative. This would be a statewide Medicaid Patient Health Service History. It would be based on claims data and allow providers access to user-friendly information vital to an individual's care.
- New Jersey Medicaid was sharing health and provider claims data with sister agencies to reduce program fraud, waste and abuse.
- Oklahoma was meeting with parties interested in forming a regional health information organization, but did not have funding at that point to support the effort.
- Utah Medicaid was part of a pilot project to exchange clinical information, medication histories, discharge summaries and chart notes.

- Wisconsin Medicaid was seeking federal grant funding. One component of the grant application focused on advancing regional health information exchange to improve health care quality and safety, and reduce redundant health care for the Medicaid population. This initiative will involve partnering with the Wisconsin Southeast RHIO to implement health information exchange between the five major hospital systems' emergency departments, Federally Qualified Health Centers, and the Health Department in Milwaukee. Implementation of this initiative is contingent on grant funding.

Thirteen state Medicaid agencies also reported they were involved in other kinds of HIT initiatives led by other agencies, and sixteen were developing other kinds of initiatives for the services they purchased or reimbursed. Examples follow.

- In Iowa there was a task force consisting of community health industry leaders and the department that was looking at strategies for encouraging use of health information exchange and electronic health records.
- Michigan Medicaid was in the process of implementing a new department-wide Medicaid Management Information System (MMIS) system. The state planned to use the new system to support benefits administration, claims and encounter processing, contract management, eligibility and enrollment, financial services, member services, program investigations, provider services, service authorizations, and referrals. Michigan Medicaid also is considering other optional services such as a pharmacy point-of-sale (POS) system. Medicaid has also worked with Blue Cross Blue Shield of Michigan to implement the web-DENIS information system allowing Medicaid providers access to patient data, such as contract eligibility, benefits covered, and more.
- New Hampshire Medicaid is the lead agency tasked with developing the Comprehensive Health Information System (CHIS), an all-payer claims data base which will include Medicaid claims.
- New Jersey Medicaid continually develops internally and partners with other state agencies to integrate systems and improve access to clinical healthcare data and provider claims data.
- Washington Medicaid was planning an information technology assessment to support the state initiative on electronic medical records, implementing a new MMIS, and planning development of a claims-based medical profile.
- The Wisconsin Medicaid Program was participating in the Wisconsin Health Information Organization's (an independent, not-for-profit consortium of health care payors, purchasers, and providers) project to create and maintain a centralized health care data repository to be used for the improvement of the quality of health care; measurement of the performance of health care providers; and creation of public reports on health care quality, affordability, safety, and efficiency. Medicaid claims data will be included in the repository. The agency also was seeking federal funding for reforming the Medicaid reimbursement system by developing and implementing value-based purchasing strategies and systems.

Promoting Population Based Health and Disease Prevention

Population based strategies are necessary to achieve impact in prevention and in 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.¹²⁵ According to *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. Individual *biology* and *behaviors* influence health through their interaction with each other and with the individual’s *social* and *physical environments*. In addition, *policies and interventions* can improve health by targeting factors related to individuals and their environments, including *access to quality health care*.”

Population based approaches to achieving improved health outcomes include a number of key functions which entail strong public sector roles and leadership. In *The Future of Public Health*, a seminal work published in 1989, 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 ten essential public health services. These core functions and essential public health services continue to guide efforts at federal, state, and local levels to achieve health improvements with population based approaches.¹²⁶

In scanning literature, the SHAPES study sought information on the extent to which states have adopted key population based health policies. Drawing on our survey results, we examine what states report doing to better integrate or coordinate public health and personal health care systems to achieve health outcome improvements.

States have adopted policies promoting improved population health in key areas

Our literature scan and selected contacts with key experts in state public health policy did not identify systematic efforts to determine and report on a set of state policies which might be viewed as key or sentinel markers or indicators of essential public health policies in a state. However, we did identify a study that sought to identify and report such indicators for promoting child health and well being.

Policy Matters sought “to focus state-level strategic thinking about, and also contribute to, a national consensus on policy directions for promoting the physical and mental health of children and families.” A health policy framework, a policy logic model, and general criteria were developed and utilized as tools by an interdisciplinary workgroup, which was charged with reaching consensus on a select number of policies with the best potential for improving family health.

Policy benchmarks relevant to population based health promotion included school health education and nutrition requirements. Figures 15 and 16 show significant variation among states in adoption of these policies which the evidence and experts have deemed to be important benchmarks for state policy. The nutrition and physical education policies are intended to improve health outcomes that include obesity and the risk it poses for chronic diseases including

diabetes, cardiovascular disease, hypertension, and certain cancers. *Policy Matters* noted that annual medical expenditures related to obesity were estimated at \$75 billion in 2003.¹²⁷ As we shall see in the next discussion of what states reported in our study, many states are implementing initiatives to better integrate or coordinate public health and health care system efforts to address what has been described as a growing epidemic.

Figure 15 State physical education requirements

How many years of physical education does the state require in elementary and secondary school?

Requirement	State
More than 10 years with no substitutions	Missouri, Montana, New York, Tennessee
More than 10 years with substitutions permitted	Alabama, Arkansas, California, Georgia, Illinois, Iowa, Kentucky, Maine, Maryland, Massachusetts, Nebraska, New Hampshire, New Mexico, North Carolina, North Dakota, Pennsylvania, Texas, Utah, Virginia, Washington
4-9 years (typically K-5 or K-6 with some secondary school requirements)	Delaware, Kansas, Louisiana, Oklahoma, Rhode Island, South Carolina, West Virginia, Wyoming
Some high school only (1-3 years)	Alaska, Connecticut*, Hawaii, Indiana, Minnesota*, Mississippi, Nevada, Oregon, South Dakota, Vermont*, Wisconsin
No specific grades are mandated	Arizona*, Colorado*, Idaho*, Michigan*, New Jersey*, Ohio*

* Ariz., Conn., Idaho, Mich., Minn., N.J., and Vt. mandate physical education as a general part of the state curriculum, but fail to specify any grades beyond limited high school graduation requirements.

Source: Center for Law and Social Policy. *Policy Matters*, January 2006.

Figure 16 State nutritional standards for food sold on school campuses

What methods does the state require to promote healthy eating in public schools?

Requirement	State
State nutritional standards for all foods sold in school	Arizona, California, Hawaii, Kentucky, Louisiana, Maine, New Jersey, North Carolina, Oklahoma, South Carolina, Tennessee, Virginia, West Virginia
Limits sale of low-nutrition food until the last lunch period is over	Alaska, Arkansas, Colorado, Connecticut, Florida, Georgia, Illinois, Maryland, Mississippi, Nebraska, New Mexico, New York, Texas
Complies with basic USDA standards only	Alaska, Delaware, District of Columbia, Idaho, Indiana, Iowa, Kansas, Massachusetts, Michigan, Minnesota, Missouri, Montana, Nevada, New Hampshire, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, South Dakota, Utah, Vermont, Washington, Wisconsin, Wyoming.

Source: Center for Law and Social Policy. *Policy Matters*, January 2006.

Most states have major initiatives to better integrate public health and health care systems to achieve improved outcomes

More than three out of four states (26 of 33) that responded to this question posed to public health agencies and governors' offices reported that they had major initiatives underway to better integrate or coordinate public health and health care systems. Of the choices offered in NASHP's survey, the most frequent focus of these initiatives was on tobacco use (23 states), obesity (21), immunizations (21), birth outcomes (17), screening (14), and substance abuse (12). Eleven states identified other major areas of focus, with those mentioned by more than one state including diabetes, asthma, injuries, and dental health. Health disparities, rural health, cancer, HIV/AIDS, emergency preparedness, mental health, health literacy and ehealth also were mentioned.

While a number of state agencies were reported to be involved in these initiatives to integrate or coordinate public health and health care system efforts, public health (25) and Medicaid (24) were reported by states to be most frequently engaged, with state employee health plans reportedly involved in 15 states, and separate SCHIP programs in 12 states. Other state agencies mentioned were mental health, education, and agencies addressing health care reform, managed health care, and statewide health planning.

Population based health promotion and disease prevention: building effective coalitions in New Mexico

Like all states, New Mexico recognizes the system-wide problem that obesity and overweight present. In response, the state engaged in a 3-year process of building a strong coalition of community, academic, government, and private partners to formulate a statewide strategic plan that has consensus support and attainable goals. In 2003, the state Department of Health was one of 28 recipients of funding from the federal Centers for Disease Control and Prevention for the development of a strategic plan to reduce obesity and related chronic diseases. In 2004, the state enlisted the help of the University of New Mexico's Prevention Research Center in holding regional workshops to identify needs and community efforts that were already under way. At the same time, the New Mexico chapter of Action for Healthy Kids held a statewide forum to develop goals, strategies, and recommendations for school nutrition and physical activity. Activities over the next two years built to the publication of *The New Mexico Plan to Promote Healthier Weight, 2006-2015*, a comprehensive strategic plan that specifies short- and long-term goals and activities involving a range of partners, with a specific focus on reducing disparities that exist in the state's Hispanic and Native American populations.

Development of the strategic plan involved the participation of more than 100 groups from a wide range of backgrounds, and the implementation of the plan requires the continued participation of many partners. Going forward, the New Mexico Healthier Weight Coalition will support work across state government agencies (the Departments of Health, Public Education, and Agriculture), as well as local governments and nonprofit agencies to promote physical activity and better nutrition among youth and their families. The Department of Health is maintaining a Web site to monitor obesity data, and the strategic plan involves evaluation of progress at 1-, 2-, 5-, and 10-year intervals. In addition to obesity, New Mexico engages in coalition building on several other health fronts, including immunizations and the formation of county health councils.

Sources: New Mexico Public Health SHAPES survey response, and The New Mexico Plan to Promote Healthier Weight, 2006-2015, available at http://www.health.state.nm.us/pdf/NM_PPHW2006Web.pdf

Population based health promotion and disease prevention incentives for wellness in Arkansas

In addition to the public coverage programs that it administers, the state of Arkansas is a very large provider of health care benefits through the plans offered to state and public school employees and their families – 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, over half of members completed this survey. 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 health risks are also eligible for 3 days of vacation as "health days."

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

Sources: Arkansas Governor's Office SHAPES survey response, presentation by Rhonda Jaster, https://arbenefits.org/ebd_pages/forms/presentationEBDStateHRABackground.pdf, presentation by Joseph Thompson, <http://www.nga.org/Files/pdf/0512HEALTHYThompsonJoe.PDF>, and Healthy Arkansas website, http://www.arkansas.gov/ha/worksite_wellness/index.html.

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CONCLUSION

Our review of existing data on state activities relevant to system performance, combined with the new data we gathered from the SHAPES survey, lead to the following conclusions.

States' multiple roles in the health care system create myriad opportunities for promoting health system performance and many states avail themselves of these opportunities. We 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 that coverage so that people can obtain benefits they need, defining minimum benefit packages, and requiring public or private coverage to address pressing unmet needs in areas such as dental care and mental health services.

States have become active in the area of promoting quality, using tools that include public reporting, purchasing specifications, and convening public and private entities that have a role in systems improvements. States continue to work to assure 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 that can improve efficiency.

Every state reported some activity promoting achievement of a high performance health system. While this finding was not unexpected, the study underscores 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 – actions and domains that our expert advisors recognize as having influence on improving system performance.

States' long-standing role in securing insurance coverage and access to health care services for vulnerable populations remains a focus of state activity in pursuit of better system performance. Rooted in the traditions of the modern welfare state, which recognizes a public responsibility for meeting the needs of those who lack the resources to meet them on their own, and encouraged and supported by federal programs, all states are playing a role in promoting more equal access to the health care system. More than four out of five states cover children at income levels that meet or exceed the minimums under federal programs. Some of these states are blazing trails in promising that all children will be covered. A number of these same states and others are moving to assure 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 and other services. Most states fund scholarships or loan repayment programs in efforts to make sure providers are available for underserved populations, and many are monitoring the health care safety net in order 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.

This study confirmed and began to paint a picture of more wide-ranging state activity in areas that historically would have been more the province of the private sector or of 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 states responding to the query reported that they require a minimum benefit package for the individual or small group market. Most states have programs in place to reduce the cost of coverage for small employers and their workers. Also, having moved over time from roles as payors for limited groups of vulnerable people to roles as major purchasers for a substantial share of the population, states are taking advantage of the opportunities to influence the content and quality of care. Most states take quality into account when making contracting decisions, and require reporting on quality measures. States are maintaining their focus on the specific needs of racially and ethnically diverse populations as well as those who are particularly vulnerable, such as children and those with disabilities, but are doing so increasingly through contractual obligations.

In addition to their roles as regulators and purchasers in the private sector, states also are serving as partners and collaborators in a number of 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. Efforts focused specifically on the safety of care were less commonly reported. And while we did not query extensively on the topic of efficiency, neither did many states volunteer to describe activity in this area. These findings may reflect the lack of a clear federal framework for action, the relatively recent emergence of these issues on the policy horizon compared to topics such as insurance coverage, or a hope or belief that federal action will supersede what states can accomplish.

In every area we examined there is room for states to do more in pursuit of a high performance health system. While the level of state activity in many areas related to health system performance is impressive, there clearly is room for growth and improvement. Although there are very real fiscal constraints to how far states can go to cover children and adults in the absence of strong federal action, many states could work to bring their coverage levels up closer to that of their peers by increasing federally matched public program eligibility levels and by further simplifying and automating enrollment and renewal processes.

More states could use their regulatory levers to influence the private marketplace to provide affordable products with adequate benefit packages. Many states and many 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, although this is another area where federal leadership and support is important. Increased involvement by more states in collaborating with

the private sector to facilitate health information exchange and technology could support more rapid adoption of systems that can aid in improving quality and efficiency of care.

Ongoing mechanisms to monitor, study and report state activities could help diffuse and speed adoption of promising and best state health system policies and practices. The SHAPES study presents a point in time picture of state activity relevant to promoting a high performance health system. Some of the policies and practices, particularly those related to public coverage, are monitored and reported on a regular basis by national organizations, including NASHP. However, many, if not most, of the others are not. As states look to other states both for ideas and for operational implementation experience, having relatively current information on which states are doing what in areas relevant to system performance would facilitate state-to-state learning and adoption of proven and promising policies and practices. Such a bank of information also would assist federal agencies, foundations, researchers, and others interested in guiding, assisting, and evaluating state efforts. SHAPES laid important groundwork in identifying relevant state policies and practices. An ongoing mechanism for obtaining similar information from surveillance of existing sources and periodic simple queries could have a substantial yield with respect to state actions in pursuit of better performance.

More in-depth exploration of specific areas of state activity could yield richer information that would aid states and the Commission on a High Performance Health System in their efforts to improve system performance. Again, as the SHAPES study brushed only 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 and where further exploration could prove fruitful included the roles of states in: assisting small employers with affordable coverage; developing minimum benefit packages for the private market (work that might also prove useful in crafting new or expanded 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 state-to-state exchange about efforts to improve health system performance also could help spur transfer of knowledge and experience about what works and spark new and innovative approaches through joint state problem solving. As with monitoring of state policies and practices, national efforts to support state-to-state learning exist, but they tend to be focused in a few specific areas, such as coverage. NASHP's experience with states 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 not only with similar health system issues, but with similar opportunities and barriers. State-to-state learning and, ultimately, national progress in achieving the attributes of a high performance health system could be accelerated if states had regular and ongoing opportunities to share ideas, lessons learned, and the operational details that can determine the success or failure of policies and practices to improve system performance.

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APPENDIX: METHODOLOGY

Conceptual Framework and Background Research

In the fall of 2005, the National Academy for State Health Policy (NASHP) developed the methodological framework for the project that became known as *State Health Policies Aimed at Promoting Excellent Systems*, or SHAPES. The goal of this project was to identify and describe important roles, policies, and practices that states are implementing which can contribute to health system transformation. We consulted closely with The Commonwealth Fund, and worked to develop our project framework and focus consistent with and complementary to the evolving efforts of the then newly created Commission on a High Performance Health System.

Based on a preliminary review of literature, our knowledge of state health policy and practice, and considering the preliminary work of the Commission in identifying the attributes of a high performance health system, NASHP developed a conceptual framework to guide a more focused literature review, as well as our data collection and final report. This framework organized Commission-identified high performance system attributes into groupings relevant to state policy and practice:

Coverage of Essential Benefits, with the goal that *all* people have equitable and affordable coverage of essential health care services

Quality, Efficiency, and Value, with the goal that *all* people get the right care at reasonable cost, and get equitable care that is, safe, patient-centered, and coordinated

Health Systems Infrastructure, with the goal that *all* people have access to systems of personal health care *and* population-based public health services that promote long and healthy lives, with this infrastructure having the capacity to improve

Given this scope and the quantity of potential state policy and practice elements that address these domains, and given time and resource limitations, we conducted most of our research using internet search tools. We reviewed material both in the grey literature as well as peer reviewed literature in key health policy journals such as *Health Affairs*. We created matrices that identified for each element its key features; rationales for the importance of the element, including any evidence base or expert policy recommendations (such as those issued by the Institute of Medicine); concerns about the element in regard to the degree of evidence or consensus on its importance; and whether and what existing information was available on relevant state policies and practices. We utilized these summary matrices to guide selection of policies and practices most critical to a high performance health system and meeting other project criteria, as well as to inform the analysis and discussion in the final SHAPES report.

Our research revealed a substantial information imbalance. The published literature and data collection about state policies related to coverage far surpass the literature and information collection available about state efforts to improve quality and efficiency, or to promote people living long and healthy lives. This led to our design decision to balance these domains by

limiting new data collection on the coverage elements and by focusing our survey work on new and promising policies and practices around other less-researched areas.

We also developed a set of criteria to guide final selection of policy and practice elements for study and reporting:

1. Policies/practices reflect state governmental action.¹²⁸
2. Policies/practices collectively address attributes of a high performance health system.
3. Policies/practices are seen as important by health systems stakeholders.
4. Policies/practices are consistent with evidence, expert consensus, or preponderance of expert opinion, including both best and promising practices.
5. Policies/practices are actionable; states can adopt or change them.
6. Policies/practices include a range in diffusion, from those adopted by a large number of states to those where a smaller number of states are acting as trendsetters.
7. Policies and practices include a range in scope, from those addressing discrete elements in one domain, to those that are broader and more systemic, touching on multiple elements and domains.
8. Policies/practices are limited in number, although they may include composite “roll-up” of more discrete elements.
9. Information about the policies/practices has been or could be collected for 50 states and the District of Columbia, preferably over time.

Our group of project advisors, drawn primarily from the Commission membership, reviewed the conceptual framework and criteria for selecting elements, and advised on which elements they deemed to: be most important; have the most evidence or consensus for affecting performance in a positive direction; and have some degree of variability among the states, as we sought neither elements that had been widely adopted nor those advanced by only a few states.

Survey Development, Fielding, Follow-up, and Response

Following the preliminary selection of potential policy and practice elements, we again reviewed the literature to examine the availability and quality of data collected on these elements for all states within recent years. Where recent data from reliable sources was available, we determined not to collect additional information. We then reviewed the remaining elements of interest to select a feasible number of elements that together met our criteria.

As we were focused on a broad range of specific policies and practices, and not just on specific programs, we determined we would need to survey a range of key state agencies that were most

likely to be engaged in developing and implementing these policies and practices. We identified five state agency types – Medicaid, SCHIP, public health, state employee health plan, and insurance – plus Governors’ health policy advisors. Working with The Commonwealth Fund, we developed surveys with some overlapping, broad questions for all agencies, and some unique and some repeated questions across agencies, depending on their possible roles on any particular element.

In September 2006 we fielded a total of 291 surveys. We conducted a number of rounds of email reminders to obtain as many surveys as possible within the approximately four months allotted for follow-up. The last several rounds of follow-up targeted the agencies we deemed most likely to be carrying out policies and practices of interest. We obtained at least one survey from each state and the District of Columbia. Our response rate by agency type was:

State agency	Number and percent of surveys returned
Medicaid	36 (71%)
Insurance	34 (67%)
Separate SCHIP (n = 36 as of 12/6/06)	24 (67%)
Public Health	27(53%)
State Employee Health Plan	16 (31%)
Governor’s Office	13 (25%)
TOTAL (single survey responses submitted by states for multiple agencies were counted as multiple surveys)	Total number of surveys received: 150 Total number of surveys sent to agencies: 291 Response rate: 52%

Analysis and Report Writing

Report responses were entered into spread sheets, initially organized by agency type. Once data entry was completed and checked, responses were reorganized by domain topics, so that the same or similar questions asked of multiple agencies were grouped together.

Responsibility for drafting the three major sections of the report corresponding to the three domains was assigned to three NASHP authors with expertise in each of the domains. These authors analyzed survey responses and synthesized them with findings from other studies identified previously through the literature review. The findings were illustrated with a small number of state vignettes drawn from survey responses and publicly available sources. Our advisory group reviewed and commented on an early draft of the report, as did staff of the Commonwealth Fund.

Limitations

This exploratory and descriptive study had a number of significant limitations. The scope of the project did not allow for pilot testing of the survey instruments; additional follow-up to obtain a higher response rate; or for follow-up with states to verify or learn more about their responses.

While the authors, in consultation with our small group of advisors, reviewed literature and considered conceptual frameworks and rationales for selection of health policies for study, opportunity to engage a larger number of experts in a more systematic process to consider and select study elements might have enriched the study. Still, given the diversity in state agency structures, functions, and responsibilities, and therefore the inherent challenges of a study of this nature, the study yielded both specific information and themes about state roles in influencing health system performance that we think will help inform work to achieve high performing health systems.

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Notes

¹ Peter Harbage and Len Nichols, *A Premium Price: The Hidden Costs All Californians Pay in Our Fragmented Health Care System* (Washington, DC: New America Foundation, December 2006).

² American College of Physicians-American Society of Internal Medicine, *No Health Insurance? It can Make You Sick* (Philadelphia: American College of Physicians-American Society of Internal Medicine, November 1999).

³ Institute of Medicine, *Care Without Coverage: Too Little, Too Late* (Washington, DC: National Academy Press, 2002).

⁴ Amy Davidoff, and Genevieve M. Kenney, *Uninsured Americans with Chronic Health Conditions: Key Findings for the National Health Interview Survey* (Washington, DC: The Urban Institute and the University of Maryland, Baltimore County [Based on data from the Centers for Disease Control and Prevention's 2003 National Health Interview Survey (NHIS)], May 2005).

⁵ American College of Physicians-American Society of Internal Medicine, *No Health Insurance? It's Enough to Make You Sick*, (November 1999) as cited in Families USA, *Paying a Premium:*

The Increased Cost of Care for the Uninsured (Washington, DC: Families USA, June 2005).

⁶ Robert C. Bradbury, et al., *Comparing Uninsured and Privately Insured Hospital Patients: Admissions Severity, Health Outcomes, and Resource Use* (Storrs, CT: Health Services Management Research, August 2001) vol. 321, no. 8 pp. 508-513, as cited in Jack Hadley, *Sicker and Poorer: The Consequences of Being Uninsured, A Review of the Research on the Relationship Between Health Insurance, Health, Work, Income and Education* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, May 2002).

⁷ Keane et al., *The Impact of Children's Health Insurance Program by Age*, *Pediatrics* 104(5): 1051-5 (1999). Data from Western Pennsylvania programs, 1995-1996. Cited in Kaiser Commission on Medicaid and the Uninsured, *Children's Health—Why Health Insurance Matters* (Washington, DC: May 2002). Access to coverage decreased the share of the same children who delayed or did not get needed prescription drugs (from 11 to 1 percent) and medical (from 25 to 3 percent), dental (from 43 to 10 percent) and vision care (from 18 to 3 percent).

⁸ Kaiser Family Foundation, *Medicaid Enrollment in 50 States: June 2005 Data Update and SCHIP Enrollment in 50 States: June 2005 Data Update* (Washington, DC: December 2006).

⁹ Kaiser Family Foundation, *Medicaid Enrollment in 50 States: June 2005 Data Update and SCHIP Enrollment in 50 States: June 2005 Data Update* (Washington, DC: December 2006).

¹⁰ This report is not intended to provide exhaustive information about Medicaid and SCHIP eligibility. For more information, see Neva Kaye and Linda Flowers, *How States Have Expanded Medicaid and SCHIP Eligibility* (Portland, ME: National Academy for State Health Policy, January 2002).

¹¹ Donna Cohen Ross, et al., *Resuming the Path to Health Coverage for Children and Parents* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, January 2007). Data as of July 2006.

¹² Alabama, California, Colorado, Connecticut, Idaho, Illinois, Iowa, Kansas, Kentucky, Louisiana, Maine, Massachusetts, Michigan, Minnesota, Mississippi, New Mexico, New York, Oklahoma, Oregon, Pennsylvania, South Carolina, Utah, Vermont, Washington, Wisconsin.

¹³ Based on NASHP scan on file with author.

¹⁴ Or higher if a state had a higher level in effect on December 19, 1989.

¹⁵ Donna Cohen Ross, et al., *Resuming the Path to Health Coverage for Children and Parents*, (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, January 2007). Data as of July 2006.

¹⁶ States must provide coverage to parents with incomes below 1996 state Aid to Families with Dependent Children (AFDC) income thresholds regardless of whether they receive cash assistance. States are able to provide coverage to parents who would have received AFDC under S. 1931 of the Medicaid Act. States can provide coverage to parents with higher incomes by using income disregards under S. 1902(r) (2).

¹⁷ Donna Cohen Ross, et al.

¹⁸ The seventeen states referred to are: Arizona, Arkansas, District of Columbia, Delaware, Hawaii, Iowa, Maine, Maryland, Iowa, Maine, Maryland, Massachusetts, Minnesota, Michigan, New Mexico, New York, Oklahoma, Oregon, Utah, and Vermont.

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- ¹⁹ Drawn from multiple sources: Neva Kaye, *State Health Care Reform Efforts in 2006*. (Portland, ME: University of Southern Maine, January 2007). Retrieved 22 March 2007. http://www.mdf.org/pla/presentations06_07/SHR.pdf. Coughlin T, "An Early Look at Ten State HIFA Medicaid Waivers," *Health Affairs* 25(3): w204-w216 (2006). Retrieved 22 March 2007. <http://content.healthaffairs.org/cgi/content/abstract/25/3/w204>. CMS 1115 waiver website, Retrieved 22 March 2007. http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/03_Research&DemonstrationProjects-Section1115.asp.
- ²⁰ Ibid.
- ²¹ Low-income immigrants may be eligible for emergency Medicaid, which covers the costs of emergency medical treatment. Additionally, the Emergency Medical Treatment and Labor Act (EMTALA) requires hospitals to screen and stabilize all individuals, including immigrants, who seek care in an emergency room.
- ²² California, Colorado, Connecticut, District of Columbia, Florida, Georgia, Idaho, Maine, Massachusetts, Minnesota, Nebraska, New Mexico, New York, Oregon, Texas, Virginia, and Washington.
- ²³ California, Colorado, Connecticut, District of Columbia, Georgia, Massachusetts, Minnesota, Nebraska, New York, Virginia.
- ²⁴ California, Colorado, Connecticut, District of Columbia, Florida, Idaho, Maine, Nebraska, New Mexico, Oregon, Texas, and Washington. Note, because of the way this question was worded, some states may have responded "yes" to the Non-Medicaid question because they cover legal immigrant children in their SCHIP programs, as permitted under federal law.
- ²⁵ Alaska, Arkansas, Arizona, California, Connecticut, Illinois, Indiana, Iowa, Kansas, Louisiana, Maine, Massachusetts, Michigan, Minnesota, Missouri, Mississippi, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Dakota, Oregon, Pennsylvania, South Carolina, Utah, Vermont, Washington, West Virginia Wisconsin, Wyoming.
- ²⁶ William E. Black and Henry T. Ireys, *Understanding Enrollment Trends and Participant Characteristics of the Medicaid Buy-In Program, 2003-2004, Final Report* (Cambridge, MA: Mathematica Policy Research, January 2006).
- ²⁷ Ibid.
- ²⁸ Alaska, Delaware, Indiana, Louisiana, Maine, New York, North Dakota, Oregon, South Carolina, Tennessee, Vermont, and Washington.
- ²⁹ The West Virginia Small Business Plan can be found at <http://www.wvsbp.org/index2.html> (Retrieved 22 March 2007). Although there is variation in premiums based on age and health status of employees, the coverage provided uses the lower reimbursement rates of the state employee plan.
- ³⁰ Nonprofits must undergo separate underwriting. *Models of Collaborative Purchasing*. (Portland, ME: National Academy for State Health Policy, June 2004). Retrieved 22 March 2007. http://www.nashp.org/Files/Collaborative_Purchasing_Matrix.doc.
- ³¹ Connecticut, Florida, Maine, North Carolina, New Hampshire, New York and Pennsylvania.
- ³² Cynthia Pernice and David Bergman, *SCHIP Buy-In Programs* (Portland, ME: National Academy for State Health Policy, May 2006). Retrieved 22 March 2007. http://www.nashp.org/Files/SCHIP_Buy-in_programs_2006.pdf.
- ³³ Dawn Gencarelli, *Health Insurance Coverage for Small Employers*. (Washington, DC: National Health Policy Forum, April 2005). Retrieved 22 March 2007. http://www.nhpf.org/pdfs_bp/BP_SmallBusiness_04-19-05.pdf.
- ³⁴ The Kaiser Family Foundation, *Health Insurance Coverage in America: 2003, Data Update*, (Washington, DC: The Kaiser Commission on Medicaid and the Uninsured, November 2004) 18.
- ³⁵ State Coverage Initiatives, *Matrix Glossary*. Retrieved 22 March 2007. <http://statecoverage.net/matrix/reinsurance.htm>.
- ³⁶ State Coverage Initiatives, *Matrix Glossary*. Retrieved 22 March 2007. <http://statecoverage.net/matrix/reinsurance.htm>.
- ³⁷ Claudia Williams, *A Snapshot of State Experience Implementing Premium Assistance Programs* (Portland, ME: National Academy for State Health Policy, April 2003) Retrieved 22 March 2007. <http://www.nashp.org/Files/snapshot.pdf>.
- ³⁸ California, Colorado, Georgia, Idaho, Illinois, Kentucky, Maine, Massachusetts, Michigan, Montana, Nevada, New Mexico, Oklahoma, Oregon, Pennsylvania, Tennessee, Utah, Vermont, Washington, Wyoming.

³⁹ Health Research and Educational Trust, *Employer Health Benefits 2006 Survey*, (Washington, DC: Kaiser Family Foundation, October 2006), Section 10. Fifty-five percent of covered workers are in self-funded plans. States cannot regulate self-insured plans where the employer, rather than the health plan benefits administrators, bears the risk for employee insurance claims. These plans are regulated solely by the Employee Retirement Income Security Act (ERISA). Fully insured plans are plans in which the benefits administrator bears the risk for employee insurance claims. These plans are regulated by state regulations, but ERISA regulations set a floor or minimum set of requirements that these health plans must follow.

⁴⁰ A number of studies examining the effects of guaranteed issue and limiting very high premiums show that these policies may expand coverage and reduce premiums for high-risk individuals, but raise premiums overall. See Deborah Chollet and Fabrice Smielauskas, *Indiana's Health Insurance Market*, (Washington, DC: Mathematica Policy Research, Inc. no date) Retrieved 22 March 2007.

<http://www.in.gov/fssa/programs/chip/insurance/pdf/MarketFinalReport.pdf>.

⁴¹ Kaiser statehealthfacts.org, "Small Group Health Insurance Market Guaranteed Issue, 2006," Data as of December 2006. Data Collection and Analysis by the Health Policy Institute, Georgetown University. Retrieved 22 March 2007. [http://www.statehealthfacts.org/cgi-](http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=compare&category=Managed+Care+%26+Health+Insurance&subcategory=Protections+in+Small+Group+Markets&topic=Small+Group+Guaranteed+Issue)

[bin/healthfacts.cgi?action=compare&category=Managed+Care+%26+Health+Insurance&subcategory=Protections+in+Small+Group+Markets&topic=Small+Group+Guaranteed+Issue](http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=compare&category=Managed+Care+%26+Health+Insurance&subcategory=Protections+in+Small+Group+Markets&topic=Small+Group+Guaranteed+Issue).

⁴² Maine, Massachusetts, New Jersey, New York, Vermont, Washington.

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[bin/healthfacts.cgi?action=compare&category=Managed+Care+%26+Health+Insurance&subcategory=Protections+in+Individual+Insurance+Markets&topic=Individual+Market+Guaranteed+Issue](http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=compare&category=Managed+Care+%26+Health+Insurance&subcategory=Protections+in+Individual+Insurance+Markets&topic=Individual+Market+Guaranteed+Issue).

⁴⁴ California, Idaho, Michigan, Ohio, Oregon, Rhode Island, Utah, West Virginia.

⁴⁵ District of Columbia, Michigan, North Carolina, Pennsylvania, Rhode Island, Virginia.

⁴⁶ Kaiser statehealthfacts.org, "Small Group Health Insurance Market Rate Restrictions," Data as of December 2006. Data Collection and Analysis by the Health Policy Institute, Georgetown University. Retrieved 22 March 2007.

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[bin/healthfacts.cgi?action=compare&category=Managed+Care+%26+Health+Insurance&subcategory=Protections+in+Small+Group+Markets&topic=Small+Group+Rate+Restrictions&gsaview=1](http://statehealthfacts.org/cgi-bin/healthfacts.cgi?action=compare&category=Managed+Care+%26+Health+Insurance&subcategory=Protections+in+Small+Group+Markets&topic=Small+Group+Rate+Restrictions&gsaview=1).

⁴⁷ Connecticut, Maine, Maryland, Massachusetts, New Jersey, Oregon, Washington. Ibid.

⁴⁸ Alabama, Alaska, Arizona, Arkansas, California, Colorado, Delaware, Florida, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, West Virginia, Wisconsin, Wyoming. Ibid.

⁴⁹ Idaho, Iowa, Kentucky, Louisiana, Minnesota, Nevada, New Hampshire, South Dakota, Utah. Ibid.

⁵⁰ Robert Wood Johnson Foundation. "Inadequate Data for Tracking State Uninsurance Rates," RWJF. Retrieved 22 March 2007. <http://www.rwjf.org/newsroom/featureDetail.jsp?featureID=909&type=3>.

⁵¹ Congressional Budget Office, "The State Children's Health Insurance Program", (Washington, D.C.: Congress of the United States, May, 2007).

⁵² Uchenna Ukaegbu and Sonya Schwartz.

⁵³ Neva Kaye, Cynthia Pernice, and Ann Cullen. *Charting SCHIP III: An Analysis of the Third Comprehensive Survey of State Children's Health Insurance Programs*, (Portland, ME: National Academy for State Health Policy, March 2006). Retrieved 22 March 2007. http://www.chipcentral.org/_catdisp_page.cfm?LID=121. See also Donna Cohen Ross et al., *Resuming the Path to Health Coverage for Children and Parents* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, January 2007). Retrieved 22 March 2007.

<http://www.kff.org/medicaid/upload/7608.pdf>.

⁵⁴ Ibid (Kaye et al.)

⁵⁵ Colorado, Connecticut, Idaho, Louisiana, Missouri, New Jersey, Tennessee, Virginia, Wyoming.

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- ⁵⁶ See also the renewal section of Neva Kaye et al.
- ⁵⁷ Colorado, Connecticut, Georgia, Idaho, Missouri, New Jersey, and Wyoming.
- ⁵⁸ Presumptive eligibility is allowed for pregnant women and kids.
- ⁵⁹ Robert L. Mollica, *Expediting Medicaid Financial Eligibility*, (New Brunswick, NJ: Rutgers Center for State Health Policy for the Community Living Exchange Collaborative: A National Technical Assistance Program, July 2004). Retrieved 22 March 2007. www.adrc-tae.org/tiki-download_file.php?fileId=1701.
- ⁶⁰ Kansas, Michigan, Nebraska, Ohio, Pennsylvania, and Washington.
- ⁶¹ Fully-insured health plans are purchased from an insurance company or other underwriter that assumes full risk for medical expenses. Under the Employee Retirement Income Security Act, states cannot regulate self-insured plans, in which employers assume the financial risk of providing coverage.
- ⁶² Note, some state responses indicate that they require a particular benefits package for their high risk pool in particular, and not the individual market at large.
- ⁶³ Colorado, Florida, Hawaii, Louisiana, Minnesota, Nebraska, New Hampshire, New Jersey, Pennsylvania.
- ⁶⁴ Colleen L. Barry and Susan H. Busch, “Do State Parity Laws Reduce the Financial Burden on Families of Children with Mental Health Care Needs?” *Health Services Research*. Forthcoming.
- ⁶⁵ Mental Health America. *What Have States Done to Ensure Insurance Parity?* (Alexandria, VA: Mental Health America, January 2007). Retrieved 22 March 2007. <http://www.mentalhealthamerica.net/go/parity/states>.
- ⁶⁶ Arizona, Arkansas, California, Colorado, Delaware, Hawaii, Illinois, Iowa, Louisiana, Massachusetts, Missouri, Montana, Nebraska, Nevada
- ⁶⁷ New Hampshire, New Jersey, New York, North Carolina, Ohio, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, West Virginia
- ⁶⁸ U.S. Department of Health and Human Services. *Oral Health in America: A Report of the Surgeon General*. (Rockville, Maryland: U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health, 2000).
- ⁶⁹ “The oral-systemic disease connection,” *Journal of the American Dental Association* 137 special supplement (October 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 Amy Brown and Beth Zimmerman, *Research to Policy and Practice Forum: Periodontal Health and Birth Outcomes—Summary of a Meeting of Maternal, Child, and Oral Health Experts*. (Washington, DC: National Maternal and Child Oral Health Resource Center, 2007)
- ⁷⁰ American Dental Association, *Status Report on State Child Health Insurance Program (SCHIP) Implementation Actions* (January 2007). Retrieved 22 March 2007. http://www.prnewswire.com/mnr/ada/26563/docs/schip_chart_2007_update.doc. Note that some states’ SCHIP programs are a combination of Medicaid expansions and stand-alone programs, and that dental benefits may only be offered to Medicaid-expansion enrollees.
- ⁷¹ Eight states offer no adult benefits at all: Alabama, Arkansas, Colorado, Delaware, District of Columbia, Missouri, Texas, and Virginia.
- ⁷² California, Connecticut, New Jersey, New York, North Dakota, Pennsylvania, Wisconsin.
- ⁷³ Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Minnesota, Montana, Nebraska, New Mexico, North Carolina, Ohio, Oregon, Rhode Island, South Dakota, Utah, Vermont, Washington.
- ⁷⁴ Alaska, Arizona, Florida, Georgia, Hawaii, Idaho, Maryland, Massachusetts, Maine, Michigan, Mississippi, New Hampshire, Nevada, Oklahoma, South Carolina, Tennessee, West Virginia, Wyoming. Medicaid/SCHIP Dental Association. *Adult Dental Benefits In Medicaid: FY 2000, 2002, 2003, 2004 & 2005*. (not dated); Retrieved 13 March 2007. <http://www.medicaidental.org/Docs/AdultDentalBenefits2003.pdf>.
- ⁷⁵ American Dental Association. *State and Community Models for Improving Dental Care Access for the Underserved – A White Paper*. (Chicago, IL: American Dental Association, October 2004). Retrieved 13 March 2007. http://www.ada.org/prof/resources/topics/topics_access_whitepaper.pdf.

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- ⁷⁷ 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, NY: The Commonwealth Fund, September 2006). Retrieved 22 March 2007. http://www.cmf.org/usr_doc/Commission_whynotthebest_951.pdf.
- ⁷⁸ Institute of Medicine, *To Err is Human: Building a Safer Health Care System* (Washington, D.C.: National Academy Press, 2000), 26. Retrieved 22 March 2007. <http://www.nap.edu/books/0309068371/html>.
- ⁷⁹ Institute of Medicine, *Patient Safety: Achieving a New Standard of Care* (Washington, D.C.: National Academy Press, 2004), p.31. Retrieved 22 March 2007. <http://books.nap.edu/openbook.php?isbn=0309090776>.
- ⁸⁰ E. A. McGlynn et.al. "The Quality of Health Care Delivered to Adults in the United States," *New England Journal of Medicine* 348, 26 (June 2003): 2635-2645.
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- ⁸² Midwest Business Group on Health. *Reducing the Costs of Poor Quality Health Care Through Responsible Purchasing Leadership* (Chicago, IL: Midwest Business Group on Health, 2003).
- ⁸³ Lisa Duchon and Vernon Smith, *Quality Performance Measurement in Medicaid and SCHIP: Results of a 2006 National Survey of State Officials* (Alexandria, VA: National Association of Children's Hospitals, August 2006), 7. Retrieved 22 March 2007. http://www.childrenshospitals.net/AM/Template.cfm?Section=Quality_Health_IT1&Template=/CM/ContentDisplay.cfm&ContentID=23432.
- ⁸⁴ Jill Rosenthal and Maureen Booth, *State Patient Safety Centers: A new Approach to Promote Patient Safety*, (Portland, Maine: National Academy for State Health Policy, 2004). Retrieved 22 March 2007. http://www.nashp.org/Files/final_web_report_11.01.04.pdf.
- ⁸⁵ Institute of Medicine, *Performance Measurement: Accelerating Improvement*, (Washington, D.C: National Academy Press, 2006). Retrieved 22 March 2007. <http://www.iom.edu/CMS/3809/19805/31310.aspx>.
- ⁸⁶ Institute of Medicine, *Crossing the Quality Chasm* (Washington, D.C: National Academy Press, 2001), 4. Retrieved 22 March 2007. <http://www.nap.edu/books/0309072808/html/>.
- ⁸⁷ California, Connecticut, Kentucky, Maine, Massachusetts, Missouri, New Mexico, Ohio, Oregon, Pennsylvania, Rhode Island, Utah, Virginia, and Wisconsin.
- ⁸⁸ Arkansas, California, Connecticut, Idaho, Maine, Massachusetts, New Mexico, Oklahoma, Oregon, South Dakota, and Wisconsin.
- ⁸⁹ Arkansas, California, Connecticut, Idaho, Maine, Massachusetts, New Mexico, Oklahoma, Oregon, Wisconsin.
- ⁹⁰ Lisa Duchon and Vernon Smith, 9.
- ⁹¹ California, Connecticut, Kentucky, Maine, Massachusetts, Missouri, New Jersey, New Mexico, Ohio, Oklahoma, Oregon, Rhode Island, Utah, Virginia, Wisconsin
- ⁹² California, Connecticut, Kentucky, Maine, Massachusetts, Missouri, New Jersey, New Mexico, Oklahoma, Oregon, Rhode Island, Utah, Virginia, Wisconsin.
- ⁹³ The Health Plan Employer Data and Information Set (HEDIS) is a set of standardized performance measures designed to ensure that purchasers and consumers have the information they need to reliably compare the performance of managed health care plans (<http://www.ncqa.org/Programs/HEDIS/>). The Consumer Assessment of Healthcare Providers and Systems (CAHPS) program is intended to provide information about the quality of health plans from the enrollees' perspective. (<https://www.cahps.ahrq.gov/default.asp>).
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- ¹⁰² *Ibid.*, 15.
- ¹⁰³ *Ibid.*
- ¹⁰⁴ *Ibid.*, 27.
- ¹⁰⁵ *Ibid.*
- ¹⁰⁶ *Ibid.*
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- ¹¹² Alabama, Connecticut, Delaware, Idaho, Maine, Massachusetts, Michigan, Minnesota, New Hampshire, Ohio, Rhode Island, Tennessee, Vermont, Wisconsin, Wyoming.
- ¹¹³ Alabama, Connecticut, Idaho, Michigan, Minnesota, Ohio, Tennessee, Vermont.
- ¹¹⁴ Arizona, Florida, Georgia, Maine, Minnesota, Nevada, Rhode Island, Washington, Wisconsin.
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¹²⁷ Center for the Study of Social Policy, *Policy Matters* (Washington, D.C.: Center for the Study of Social Policy, 2006).

¹²⁸ Lead or substantial collaborative role of state government in actions that include legislating, regulating, requiring via contract, financing, purchasing, encouraging or discouraging via financial and non-financial rewards or penalties, providing guidance, providing technical assistance, publicly reporting, and convening.

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