



Aiming Higher

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Commonwealth Fund's Commission on a High Performance Health System

Objective:

- Move the U.S. toward a higher-performing health care system that achieves better access, improved quality, and greater efficiency, with particular focus on the most vulnerable due to income, gaps in insurance coverage, race/ethnicity, health, or age



State Scorecard: Purpose and Methods

- Aims to stimulate discussion, collaboration, and policy action
- Modeled on National Scorecard
 - 5 dimensions: access, quality, avoidable hospital use and costs, equity, and healthy lives
 - Contrasts to highest performers
- Ranks states on indicators and dimensions
 - 32 indicators
 - Dimension rank based on average of indicator ranks
 - Overall rank based on average of dimension ranks
- Equity
 - Gaps for vulnerable group (income, insurance, race/ethnicity) on subset of 11 indicators



Key Findings

- Wide variation among states, huge potential to improve
 - Two- to three-fold differences in many indicators
 - Leaders offer benchmarks
- Leading states consistently out-perform lagging states
 - Suggests policies and systems linked to better performance
 - Distinct regional patterns, but also exceptions
- Access and quality highly correlated across states
- Significant opportunities to address cost, quality, access
 - Quality not associated with higher cost across states
- All states have room to improve
 - Even best states perform poorly on some indicators



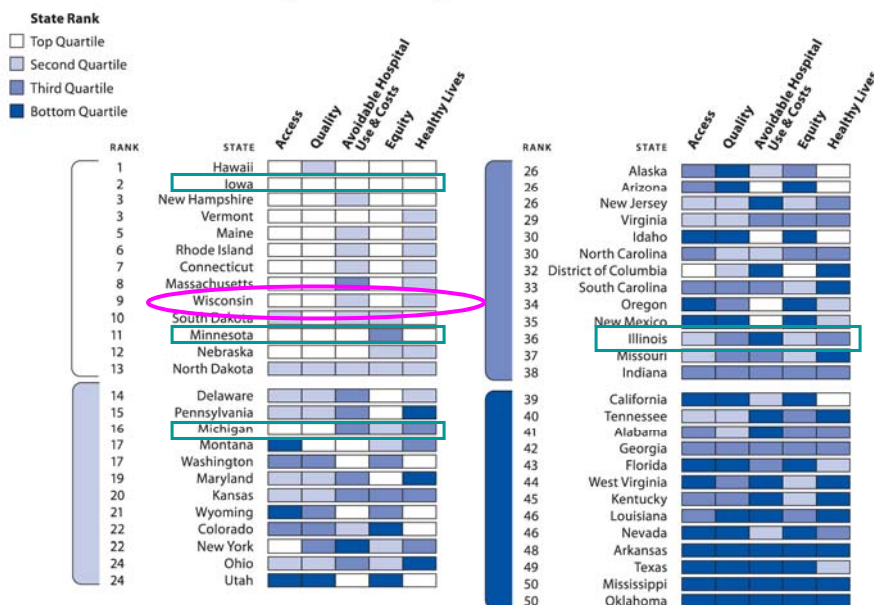
Gains if Wisconsin Achieved Top State Performance

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- **More People Covered**
 - Over 100,000 additional adults and children insured
- **More Getting the Right Care**
 - Nearly 102,000 additional adults (age 50+) and over 35,000 diabetics would receive recommended care
 - Nearly 12,000 children immunized
- **More Getting Primary Care**
 - 237,000 adults and 130,000 children with primary care
- **Less Avoidable Hospital Utilization**
 - Over 15,000 fewer Medicare hospital admissions and readmissions per year (Savings of \$86 million+ per year)
- **Healthy Lives**
 - 822 fewer premature deaths



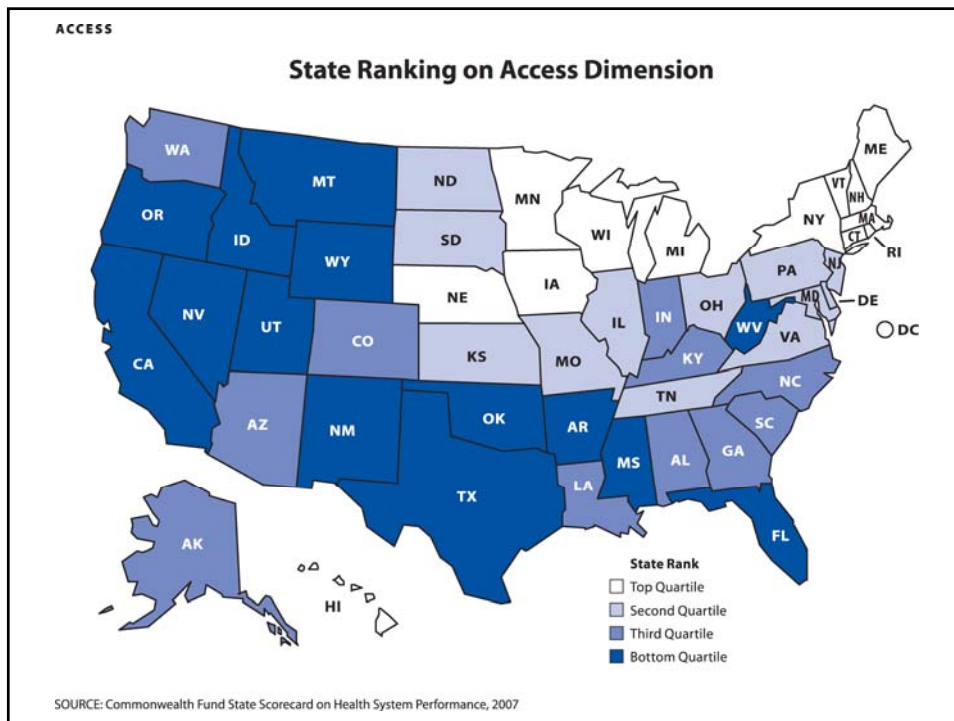
State Scorecard Summary of Health System Performance Across Dimensions



SOURCE: Commonwealth Fund State Scorecard on Health System Performance, 2007

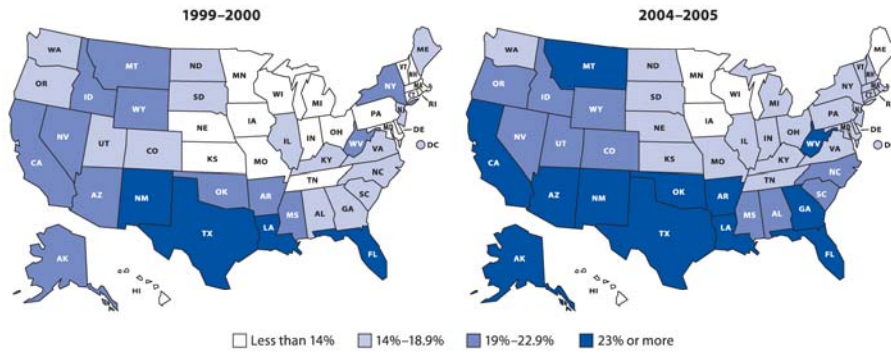
Summary of Indicator Rankings for Wisconsin

| DOMAIN (# indicators): | Top Quartile | Second Quartile | Third Quartile | Bottom Quartile |
|----------------------------|-----------------|--------------------|-------------------|--------------------|
| ACCESS (4) | 3 | 0 | 0 | 1 |
| QUALITY (14) | 7 | 6 | 1 | 0 |
| AVOIDABLE USE/COSTS (9) | 3 | 5 | 0 | 1 |
| HEALTHY LIVES (5) | 0 | 5 | 0 | 0 |
| TOTAL (32) | 13 | 16 | 1 | 2 |



ACCESS

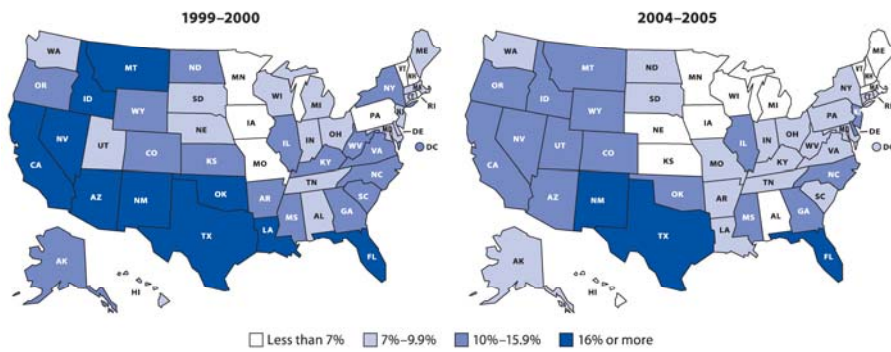
Percent of Adults Ages 18–64 Uninsured by State



DATA: Census Bureau's March 2000, 2001 and 2005, 2006 Current Population Survey
SOURCE: Commonwealth Fund State Scorecard on Health System Performance, 2007

ACCESS

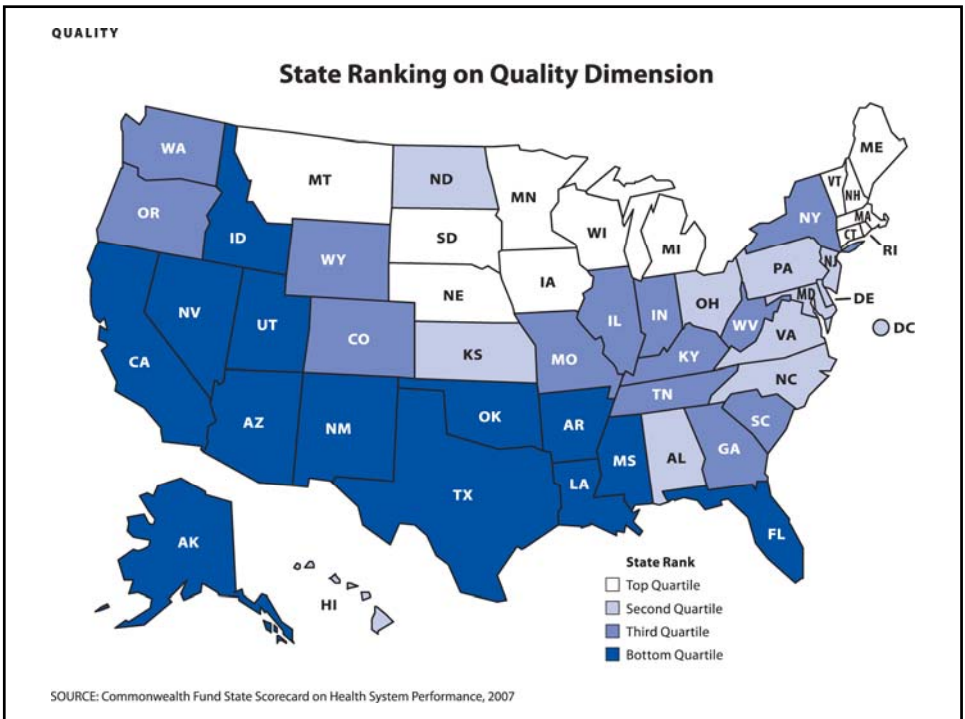
Percent of Children Ages 0–17 Uninsured by State

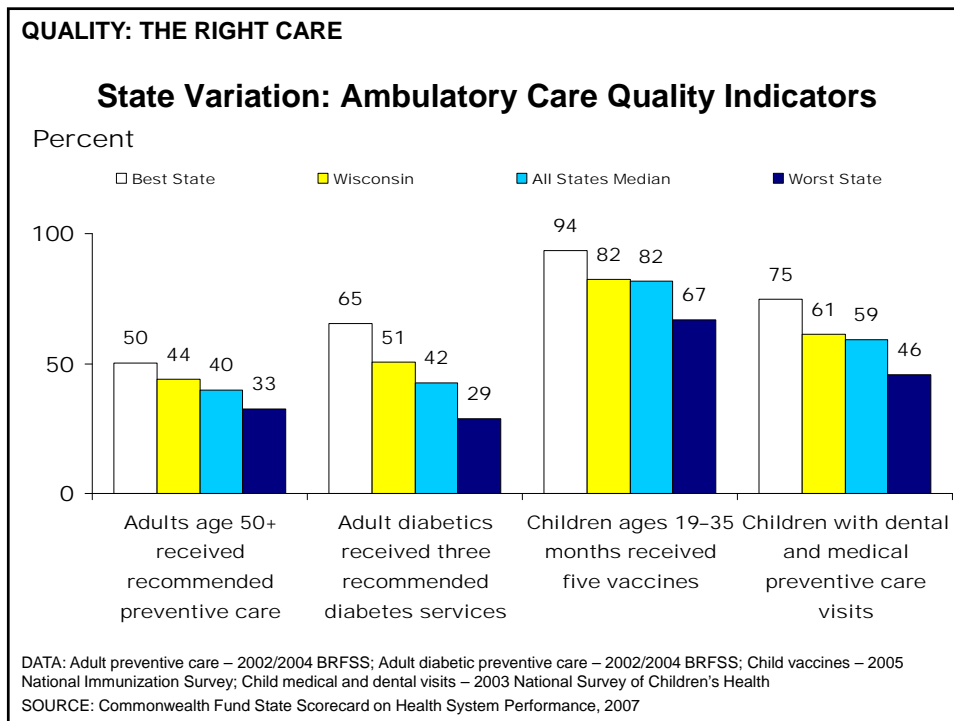
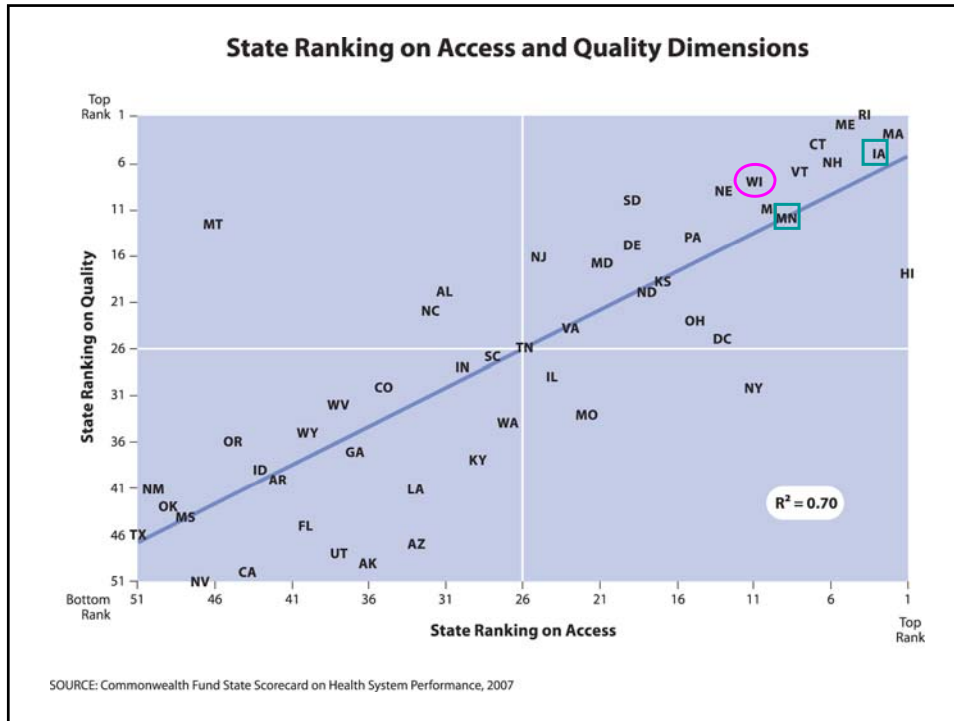


DATA: Census Bureau's March 2000, 2001 and 2005, 2006 Current Population Survey
SOURCE: Commonwealth Fund State Scorecard on Health System Performance, 2007

QUALITY

- Getting the Right Care
- Coordinated Care
- Patient-Centered Care

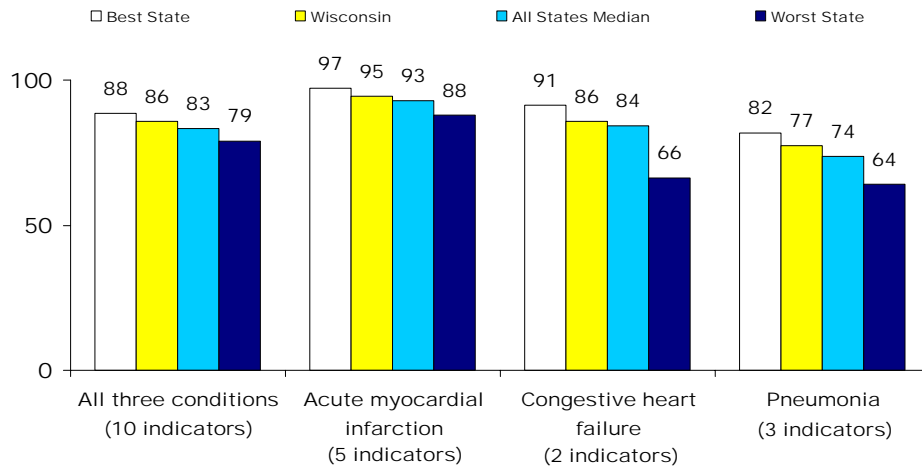




QUALITY: THE RIGHT CARE

State Variation: Hospital Care Quality Indicators, 2004

Percent of patients who received recommended care

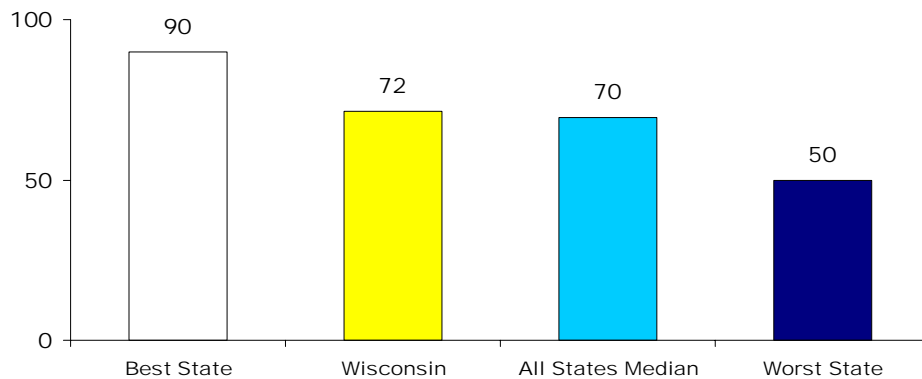


DATA: 2004 CMS Hospital Compare
 SOURCE: Commonwealth Fund State Scorecard on Health System Performance, 2007

QUALITY: THE RIGHT CARE

State Variation: Surgical Infection Prevention, 2005

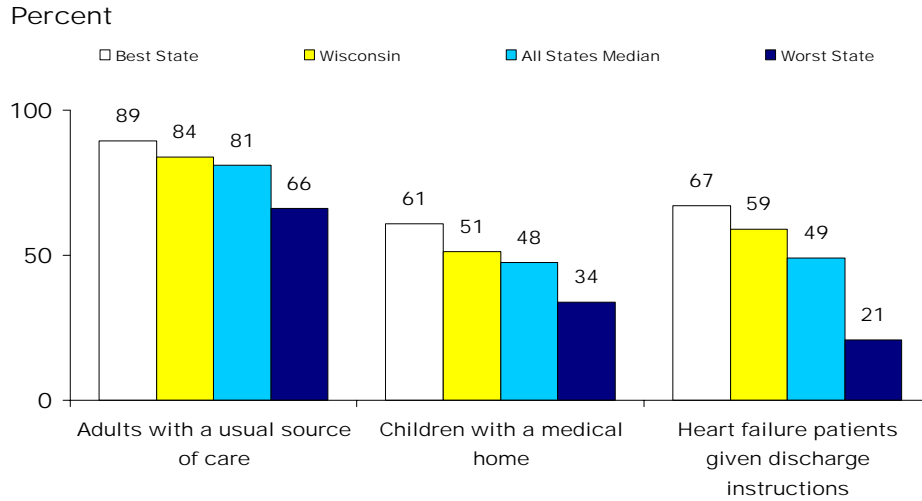
Percent of adult surgical patients who received appropriate timing of antibiotics to prevent infections*



* Comprised of two indicators: before and after surgery.
 DATA: 2005 CMS Hospital Compare
 SOURCE: Commonwealth Fund State Scorecard on Health System Performance, 2007

QUALITY: COORDINATED CARE

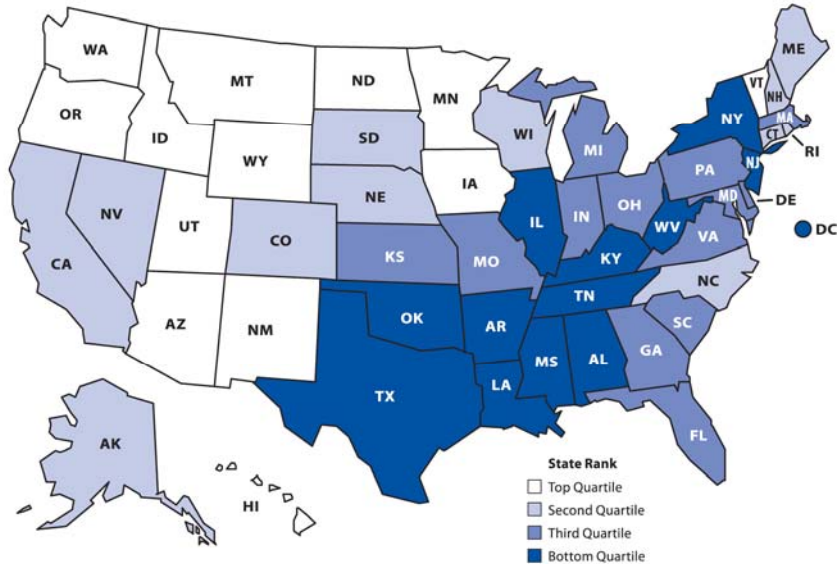
State Variation: Coordination of Care Indicators



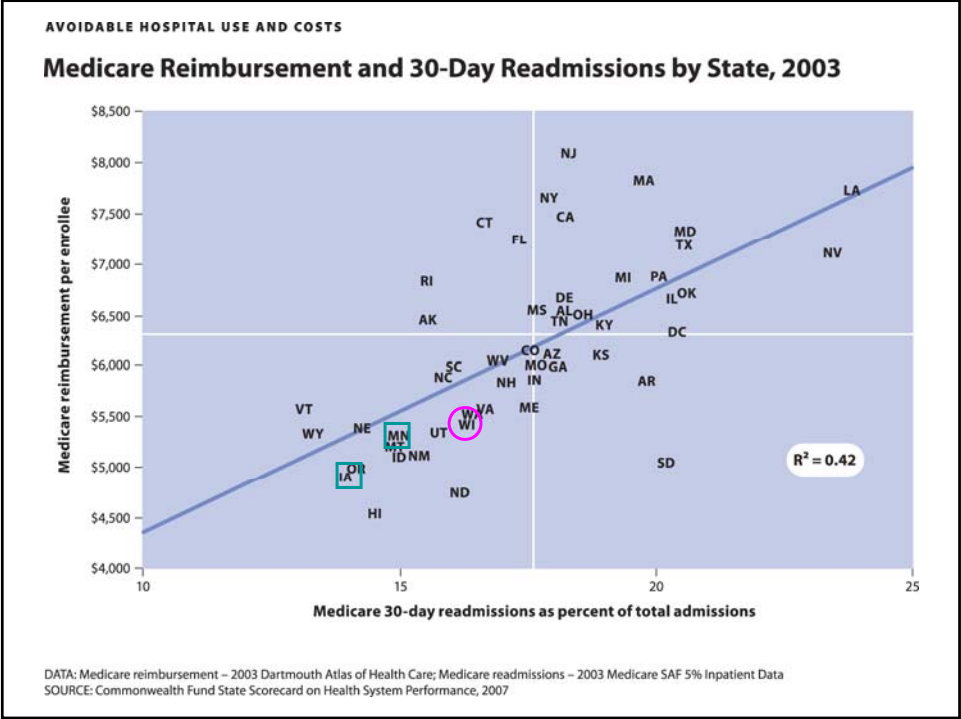
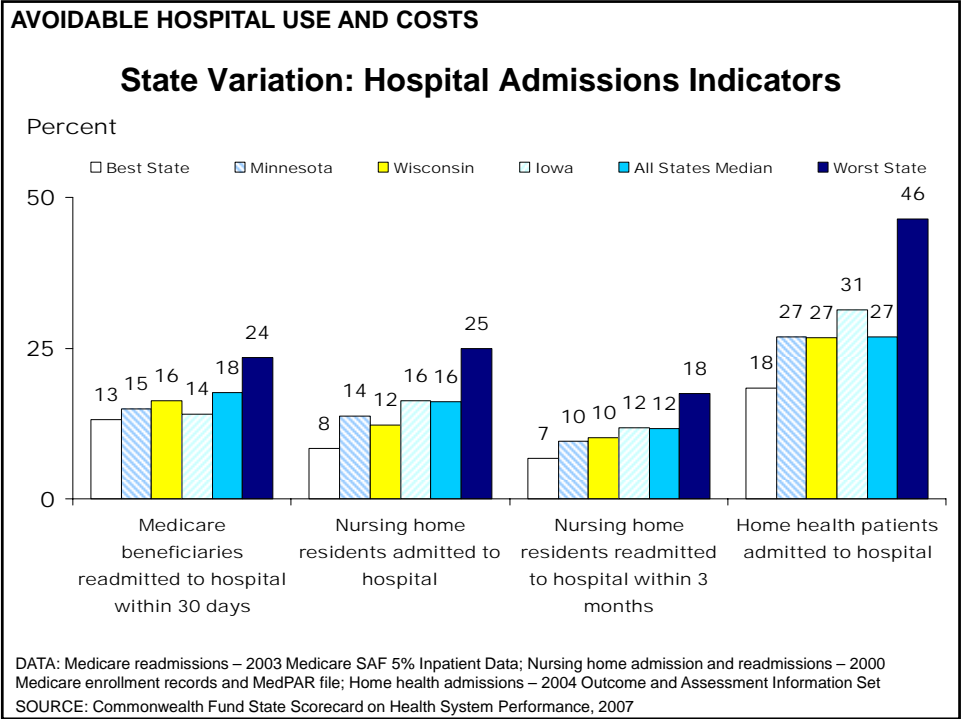
DATA: Adult usual source of care – 2002/2004 BRFSS; Child medical home – 2003 National Survey of Children’s Health; Heart failure discharge instructions – 2004-2005 CMS Hospital Compare
 SOURCE: Commonwealth Fund State Scorecard on Health System Performance, 2007

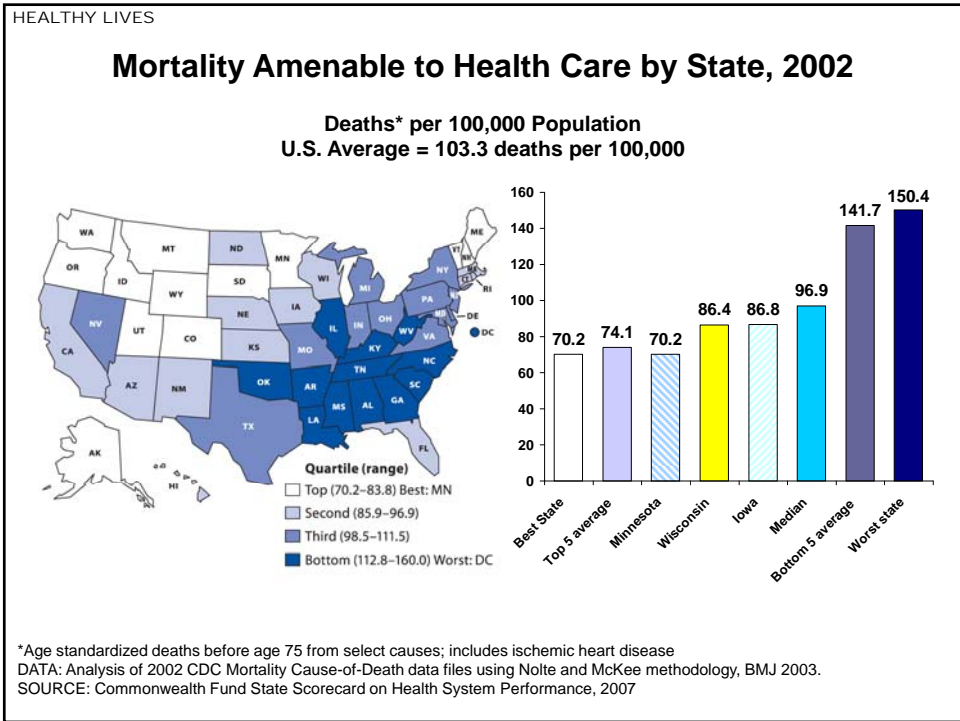
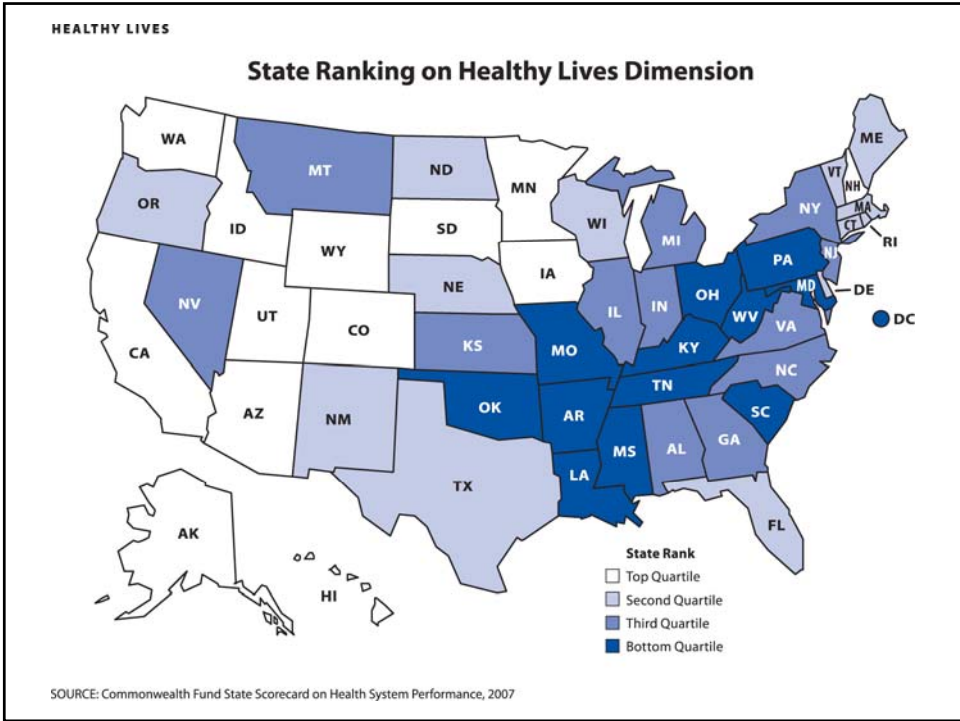
AVOIDABLE HOSPITAL USE AND COSTS

State Ranking on Potentially Avoidable Use of Hospitals and Costs of Care Dimension



SOURCE: Commonwealth Fund State Scorecard on Health System Performance, 2007

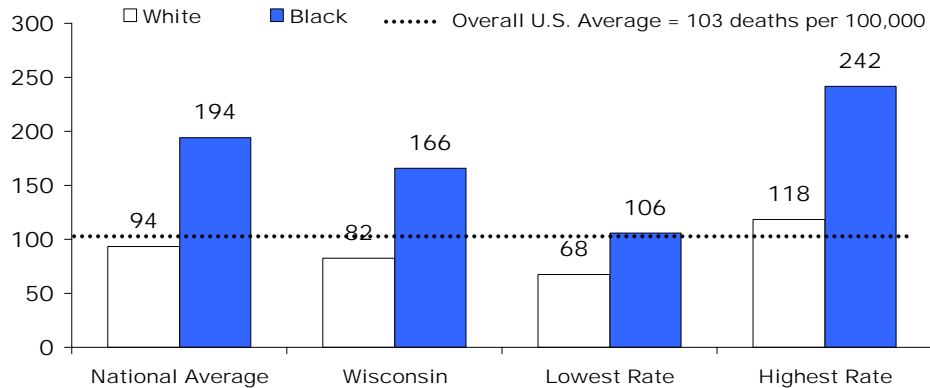




HEALTHY LIVES

Mortality Amenable to Health Care by Race, National Average and State Variation

Deaths* per 100,000 Population



*Age-standardized deaths before age 75 from select causes; includes ischemic heart disease

DATA: Analysis of 2002 CDC Multiple Cause-of-Death data files using Nolte and McKee methodology, *BMJ* 2003.
SOURCE: Commonwealth Fund State Scorecard on Health System Performance, 2007

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Lessons From The Scorecard

- Care far from “perfect”
- Tremendous variation within the U.S.
- Possible to have higher quality and lower cost
- We need to address multiple issues simultaneously – e.g., coverage, efficiency, quality





States Can Promote a High Performance Health System

1. Extend health insurance coverage to all
2. Pursue excellence in provision of safe, effective, and efficient care
3. Organize the care system to ensure coordinated and accessible care for all
4. Increase transparency and reward quality and efficiency
5. Expand the use of information technology and information exchange
6. Develop the workforce to foster patient-centered and primary care
7. Encourage leadership and collaboration among public and private stakeholders

Source: The Commonwealth Fund's Commission on a High Performance Health System: *Keys to Transforming the U.S. Healthcare System*



What States Can Do to Promote a High Performance Health System: *Strategies to Expand Coverage*

- **Design shared responsibility strategy to include state, employers and individuals**
 - Expand public programs
 - Require "play-or-pay" for employers
 - Encourage offering Section 125 benefit plans
 - Mandate individuals to purchase coverage
 - Provide financial assistance to low-income workers and employers to afford coverage
- **Pool purchasing power and promote new benefit designs to make coverage more affordable**
- **Develop reinsurance programs to make coverage more affordable in the small group and individual markets**
- **Require insurers to raise age limit for dependents**



Components of Comprehensive State Reform Plans

| | ME | MA | CA | PA | IL | NY Blueprint |
|-------------------------------------|----|----|----|-----------|----|--------------|
| Individual Mandate | | X | X | >300% FPL | X | X |
| Employer Shared Responsibility | X | X | X | X | X | X |
| Public Program Expansion | X | X | X | X | X | X |
| Risk pooling | X | X | X | X | X | X |
| Subsidies for Low-income Uninsured | X | X | X | X | X | X |
| Wellness/Preventive Health Emphasis | X | X | X | X | X | |
| Quality Improvement Components | X | | X | X | X | X |
| Provider Fee Assessment | | | X | | | |



Universal Coverage Goal: Massachusetts Health Plan

- MassHealth (Medicaid) expansion for children up to 300% FPL plus new Commonwealth Care Insurance Program for low-income individuals with subsidized premiums up to 300% FPL
- Individual mandate for adults (financial penalty via income tax filing)
- Employers (11+ employees) must make "fair and reasonable" premium contributions or pay \$295 "fair-share" assessment plus "free-rider" surcharge if employees make excessive use of uncompensated care
- Connector approves affordable insurance offerings for small groups and individuals (special low-cost product for those ages 19-26)
- Market reform: merging individual and small-group insurance markets
- Redistribution of existing uncompensated care financing plus new funding from employer contributions and general revenues
- 100,000 previously uninsured gained coverage as of May 2007

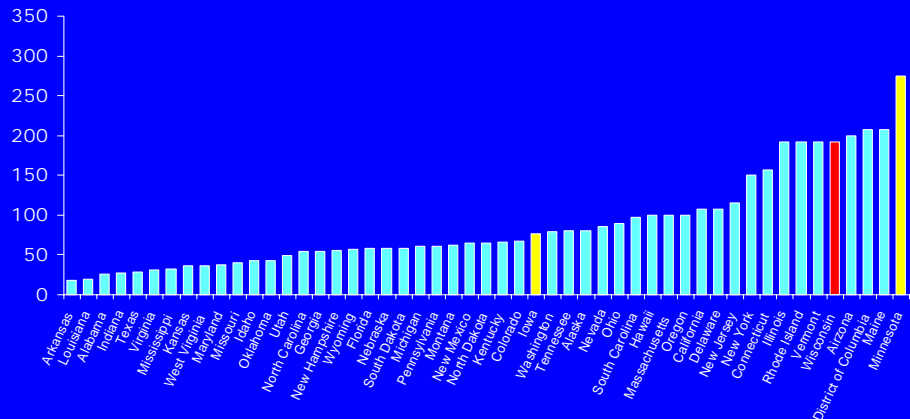
Sources: Kaiser Commission on Medicaid and the Uninsured, June 2007; JE McDonough et al. The Third Wave Of Massachusetts Health Care Access Reform. *Health Affairs* Nov/Dec 2006; 25(6): w420-w431.



States' Income Eligibility Levels for Medicaid/SCHIP for Parents

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States' Medicaid/SCHIP eligibility levels for parents



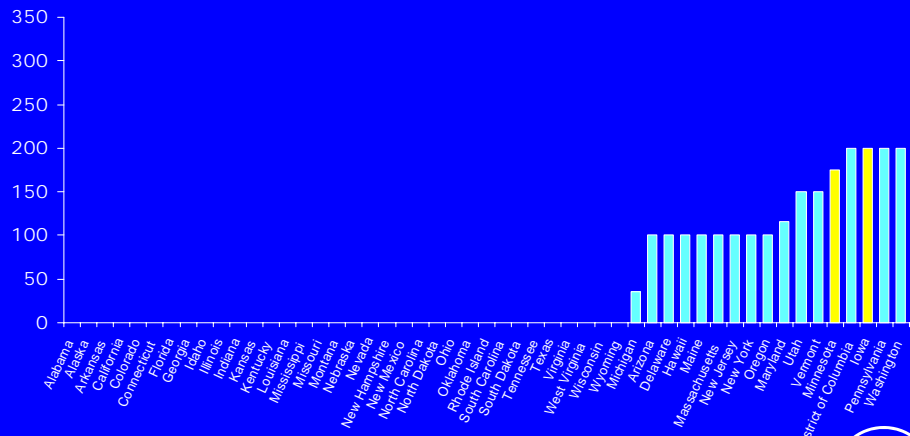
Source: Kaiser Family Foundation, "Income Eligibility for Parents applying for Medicaid, 2006" available online at <http://www.statehealthfacts.org>, accessed on February 9, 2007.



States' Income Eligibility Levels for Medicaid/SCHIP for Non-Parent Adults

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States' Medicaid/SCHIP eligibility levels for non-parent adults



Source: State Coverage Initiatives, current as of October 2006.



State Coverage Expansion Targeting Employees of Small Businesses



- Governor recently authorized expansion from 50 to 250 employees and from 185% to 250% FPL
- Available to individuals on a sliding scale
- Premium assistance pays 60% of premium for low income workers; employer pays 25%; employee pays up to 15%
 - Funded from tobacco tax, federal Medicaid match, and employer/employee contributions
 - Waiver amendment to be submitted to CMS
- Small employers with 30% or more employees earning <\$35,500
- 125,000 enrollees as of Fall 2006
- State reinsurance keeps premiums affordable
 - State reimburses health plans 90% of claims paid between \$5,000 and \$75,000 on behalf of a member in a calendar year (reduced from \$30,000 to \$100,000 originally)
 - Most plans reduced premiums by approximately 17% as a result of change in risk-corridor
- Premiums range from \$656-\$879 for family and \$219-\$302 for individual



What States Can Do to Promote a High Performance Health System: *Strategies to Improve Quality and Efficiency*

- Provide incentives for improved performance
 - Promote/practice value-based purchasing (P)
 - Pay-for-performance
 - Selective purchasing/tiering
 - Value-based benefit designs
- Promote better organization/integration
 - Promote the use of health information technology (L, T, P, R)
 - Includes information exchange, ambulatory & hospital systems
 - Promote transitional care at hospital discharge
 - Including reporting requirements (State of Maine) (T, P)
 - Encourage development and selection of a medical home
 - Improved access to primary care/preventive services (P)
 - Non-emergency settings for non-emergency care (P)

ROLES: P=purchasing, L=legislating, T=technical support, R=regulating





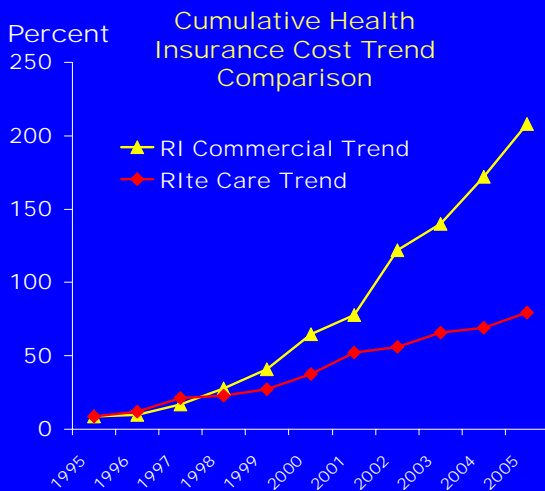
What the Neighbor is Doing: Minnesota Value Initiatives

- **Smart Buy Alliance (formed 2004):** coalition of coalitions representing state, business & labor that purchase coverage for 60% of state residents: collectively drive value in health care delivery by:
 1. Identifying and rewarding “best in class” providers
 2. Adopting uniform measures of quality and results
 3. Empowering consumers with easy access to information
 4. Accelerating use of latest health information technology
- **Minnesota Advantage (public employee plan)** savings from incentives and health promotion strategies: 0% premium increase for 2006; \$20 million in savings is being returned to state employees
- **QCare: Quality Care and Rewarding Excellence (public coverage)**
 - Pay-for-performance for clinics meeting goals for chronic care management
 - Patient incentives to be developed for meeting health goals
 - Provider-directed care coordination pilot for Medicaid patients with complex chronic illnesses (\$50 PMPM)
- **Public-private web-based primary care access pilot** to connect patients to medical home and reduce non-emergency use of ER

Source: T. Alteras and S. Silow-Carroll, Minnesota Smart Buy Alliance, The Commonwealth Fund (forthcoming); Minnesota Dept. of Human Services, 2007 Legislative Session Fast Facts; Legislative text



Building Quality Into Rlte Care Higher Quality and Improved Cost Trends



- **Quality targets and \$ incentives**
- **Improved access, medical home**
 - One third reduction in hospital and ER
 - Tripled primary care doctors
 - Doubled clinic visits
- **Significant improvements in prenatal care, birth spacing, lead paint abatement, infant mortality, preventive care**

Source: Silow-Carroll, *Building Quality into Rlte Care*, Commonwealth Fund, 2003. Tricia Leddy, *Outcome Update*, Presentation at Princeton Conference, May 20, 2005; updated.





Information Exchange: States Leading the Way



New York State Health Information Technology (HIT) initiative

- \$52.9 million awarded to 26 regional health networks to expand technology in NY health care system and support clinical data exchange

Minnesota: Administrative Efficiency

- Starting in 2009, all health care providers and insurers will be required to file health care claims electronically in a standard format
- A consortium of payers, providers, state agencies is developing format
- Reduce claims submission costs in half (\$0.85 electronic vs. \$1.58 paper)

Delaware Health Information Network/Information Exchange

- Public-private partnership (1997)
- Functions under the direction of the Delaware Health Care Commission
- In 2006 signed an extendable 6-year contract to create the first statewide health information exchange (start-up costs = \$4 to 5 million)
 - Access to secure, fast, and reliable electronic patient information at the time and place of care
 - Funded by participating health care organizations, State of Delaware, and federal agencies

Source: Evolution of State Health Information Exchange, AHRQ, Publication No. 06-0057, January 2006.
Minnesota Dept. of Health, News Release, June 27, 2007.



What States Can Do to Promote a High Performance Health System: *Strategies to Improve Quality and Efficiency*

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- Promote population health
 - Effective chronic care management (P, T)
 - Promote wellness and healthy living (P, T, L)
- Workforce improvement
 - Use licensure authority creatively to ensure access and promote health (R,L,T)

ROLES: P=purchasing, L=legislating, T=technical support, R=regulating



Wellness & Preventive Health Initiatives



- A statewide effort to improve the health of all Oklahomans by sharing ideas for healthy eating, getting more exercise, and being tobacco-free
- Turning Point: More than 50 local partnerships meet on a regular basis to talk about health issues and create policies to make Oklahoma a healthier place to live
- Workforce wellness programs and Healthy schools (PE and nutrition)
- Public-private partnership to refocus health care from reactive to proactive
- Information, tools and support that patients and providers need to successfully manage chronic conditions
- Developing a web-based chronic care patient information system
- Healthy Living Workshops (state funded; referred by physician); patients report improved health, reduced MD/ER visits
- Obesity prevention initiatives



Arkansas Act 1220 of 2003

- ▣ Mandated that parents receive their child's body mass index (BMI)
- ▣ Prohibited in-school access to vending machines in elementary schools
- ▣ Called for the incorporation of nutrition and physical activity goals into annual school planning and reporting

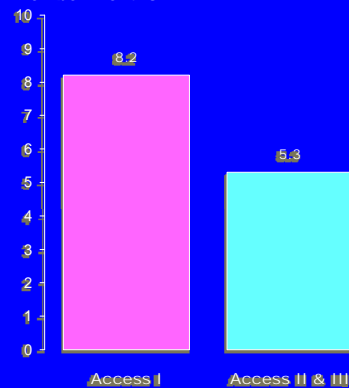


Community Care of North Carolina



Asthma Initiative: Pediatric Asthma Hospitalization Rates (April 2000 – December 2002)

Inpatient admission rate per 1000 member months



- State-local partnership involving 3,500 MDs caring for >750,000 Medicaid patients
- State provides funding, information, and technical support
- 15 local nonprofit networks (including PCPs, hospital, county Medicaid and health depts) receive \$2.50 PMPM for population care management, e.g., hiring care managers
- PCPs receive \$2.50 PMPM to serve as medical home and participate in disease management
- Care improvement: asthma, diabetes, screening/referral of young children for developmental problems, and more
- Cost: \$8.1 million (FY2003); estimated savings of \$50-70 million in 2003 (Mercer analysis)

Source: L. Allen Dobson, MD, presentation to ERISA Industry Committee, Washington, DC, March 12, 2007. American Academy of Family Physicians, Case-Study: Community Care of North Carolina, June 2006



What States Can Do to Promote a High Performance Health System: *Strategies to Improve Quality and Efficiency*

- Use better information to guide and drive improvement
 - Promote evidence-based medicine and shared-decision making (P, L, T)
 - Encourage data transparency and reporting on performance (P, L, T, R)
 - Identify/spread best practices (T)
- Collaborative continuous improvement
 - Convening around data (T,P)
 - Convening around techniques/processes – e.g., teamwork, improvement of patient flow (T,P)

ROLES: P=purchasing, L=legislating, T=technical support, R=regulating



Wisconsin Leadership: Building Blocks for High Performance



VALUE PURCHASING

- Wisconsin Collaborative for Healthcare Quality
- Wisconsin Purchasers for Quality
- Wisconsin Employee Trust Funds
- Wisconsin Health Information Organization
- Wisconsin Hospital Association's CheckPoint and PricePoint

COLLABORATIVE QUALITY IMPROVEMENT

- Wisconsin Collaborative Diabetes Quality Improvement Project
- Safe Care Wisconsin: Partners for Advancing Health Care Safety
- Pharmacy Society Collaborative: Medication Therapy Management Service Initiative
- MetaStar (Wisconsin's Medicare Quality Improvement Organization)
- Medicaid Encounter Data-Driven Improvement Core Measurement Set (MEDDIC-MS) and Medicaid HMO Accreditation Incentive



Aiming Higher

Urgent need for action that takes a whole-system population perspective and addresses access, quality and efficiency

- Universal coverage with meaningful access: foundation for quality and efficient care
- Wide variations point to opportunities to learn
- Information systems and better information are critical for improvement
- National leadership and public and private collaborative improvement initiatives



Acknowledgements and Related Commission Reports

- ***Aiming Higher: Results from a State Scorecard on Health System Performance (June 2007).*** The Commonwealth Fund Commission on a High Performance Health System. Authors:
 - Joel C. Cantor and Dina Belloff, Rutgers University Center for State Health Policy
 - Cathy Schoen, Sabrina K.H. How, and Douglas McCarthy, The Commonwealth Fund
- **Related Commonwealth Fund Commission Reports**
 - ***Why Not the Best? Results from a National Scorecard on U.S. Health System Performance (Sept. 2006).*** The Commonwealth Fund Commission on a High Performance Health System.
 - ***Framework for a High Performance Health System for the United States (Aug. 2006).*** The Commonwealth Fund Commission on a High Performance Health System.

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