

States in Action: A Bimonthly Look at Innovations in Health Policy, March/April 2007

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Profile: In-Depth Look at an Initiative that Is Making a Difference

Comprehensive State Reforms Address Health Care Quality and Efficiency

State legislatures and governors are increasingly proposing or implementing comprehensive health care reform plans that extend beyond coverage expansion to address the quality of care, health promotion, and cost containment. These multifaceted plans aim to improve the overall performance of the health system—recognizing the imperative to increase the value of care obtained for the dollars spent. Maine, Massachusetts, and Vermont have passed and are implementing such comprehensive reforms, and governors and legislators in many other states, including California, Maryland, Pennsylvania, and Wisconsin, are introducing variations of these [reforms as well as new strategies](#). Since others have written about the [coverage aspects of reform plans](#), this profile focuses on their efforts to address health care quality and efficiency.

Most of the quality and efficiency strategies are related to *chronic care management, wellness and prevention, patient safety, and transparency through data collection and health information technology*. Proponents of these strategies emphasize that these measures to improve the quality of care and health status are integrally tied to *cost containment*. They argue that practices that help people achieve healthier lives, help providers reduce errors, and help purchasers make better, more informed decisions also generate savings in the long run. The reform plans include both incentives and mandates, both "carrots" and "sticks."

A primary focus of many of these comprehensive reform plans is *chronic care management*, particularly for asthma, diabetes, and heart and lung disease. Policymakers cite data illustrating that the majority of health care costs are attributed to a minority of patients with chronic disease, and that these patients are not receiving the right amount or

best kind of care. For example, Pennsylvania's Governor Rendell points out that, "Even though 75 percent of health care costs can be traced to the 25 percent of patients with chronic disease, these Pennsylvanians received only 56 percent of the care they need." [1] The reform proposals seek to increase use of nationally proven models or "best practices" for treating chronic disease through pay-for-performance and other incentives to providers.

The reform plans also promote *prevention and wellness*, with a particular focus on tobacco use and obesity. They feature nutrition counseling, smoking cessation, and exercise programs, provided through such mechanisms as telephone help lines, schools, and community partnerships. Some reform proposals would establish insurance plans that reduce premiums or copayments if enrollees engage in healthy activities.

Comprehensive reform plans also include provisions to support *health information technology* that promotes *patient safety* (e.g., electronic medical records, e-prescribing), *data collection*, and *public reporting*. Proponents expect that making comparative performance information available to purchasers of health care, including state agencies, employers, and consumers, will enable them to make better choices. Such data could also encourage providers to improve the quality and efficiency of the care they provide.

Vermont's Blueprint for Health

Vermont's 2006 [Health Care Affordability Act](#) pursues coverage expansion through the creation of comprehensive and affordable private insurance ("Catamount Health" plans) and through premium assistance to low-wage workers. But the legislation's overriding goal is to control steeply rising health care costs. To achieve this, the act focuses on managing chronic care, which accounts for 70 percent of the state's health care spending. The state is establishing a chronic care management system available to all residents based largely on the state's "Blueprint for Health." [2] Features include:

- an extensive care coordination system including early and coordinated screening for diabetes, asthma, and other chronic conditions; the state is targeting 1,200 of the highest-need Medicaid beneficiaries annually, and field staff are being hired and trained;
- reimbursement to providers that encourages care management and high quality (versus quantity), such as home visits, appointment reminders, and follow-up work;
- patient self-management educational tools, as well as education of providers and other stakeholders in promoting self-management;
- Medicaid and Catamount Health and the state employee health plan contract for disease/chronic care management, which is designed to reduce costs;
- community grants to develop physical activity programs; and
- development of a multi-payer database of claims information to help the state analyze the efficiency and effectiveness of the health care system.

California Governor's Health Care Proposal

In addition to incorporating measures that would cover virtually all Californians—through an individual mandate, premium assistance, State Children's Health Insurance Program (SCHIP) expansion, and a new purchasing mechanism—Governor Schwarzenegger's recent reform proposal places a strong emphasis on prevention, health promotion, and wellness. It includes:

- "Healthy Action Incentives/Rewards" programs in the public and private sectors to offer enhanced benefits and/or reduced insurance premiums to participants who engage in healthy activities;
- promotion of patient safety through: requirement on health facilities to reduce medical errors and hospital-acquired infections by 10 percent over four years, technical assistance to implement evidence-based safety measures, and creation of a "reengineering" curriculum to improve safety and streamline costs;
- statewide diabetes initiative to implement proven interventions for screening, primary prevention, and self-management; this would reduce health costs by reducing the incidence of diabetes and improving the health of people with diabetes;
- obesity prevention activities including media campaigns, community-based activities to promote healthy food and physical activity, employee wellness programs, and school-based strategies; and
- tobacco use reduction, by increasing access to the California Smokers' Helpline smoking cessation services and maximizing use of cessation benefits.

These efforts to promote a healthier lifestyle are expected to reduce health spending growth. But the governor's approach also contains other cost containment measures, such as:

- eliminating the "hidden tax" that results from shifting costs from uninsured and Medicaid patients to privately insured individuals, estimated to drive prices 10 percent higher; [\[3\]](#)
- enhancing efficiency by requiring health plans, insurers, and hospitals to spend at least 85 percent of each premium/health spending dollar on patient care;
- removing barriers to lower-cost models of care delivery such as the use of nurse practitioners and physician assistants;
- developing a technology assessment process to promote evidence-based care;
- advancing the adoption of health information technology (expected to enhance long-term affordability) to achieve 100 percent electronic health data exchange in the next 10 years, universal e-prescribing by 2010, accessible and portable personal health records, and use of telemedicine and telehealth, particularly in underserved areas; and
- investing resources to measure, collect, integrate, and publicly report data on provider quality, outcomes, cost, prices, and utilization to help inform providers, purchasers, and consumers and drive their decision-making.

Governor Rendell's "Prescription for Pennsylvania"

Governor Rendell introduced a similar comprehensive health reform plan in January intended to provide access to affordable, quality health care for all state residents. It features an individual mandate on those with income above 300 percent of the federal poverty level, and a "Cover all Pennsylvanians" (CAP) program that offers basic, private health coverage to small businesses and the uninsured, with subsidies for lower-income people. [4] Following are the quality improvement features:

- requirement that hospitals adopt system-wide quality management/ error reduction systems and interoperable electronic medical records;
- pay-for-performance initiative led by the state and other major payers, and eventual cessation of payments to providers for care related to hospital-acquired infections and medical errors;
- alignment of payments to support the use of the national chronic care model;
- development of an integrated model of care for individuals with co-occurring disorders, including substance abuse or mental disorders;
- expansion of palliative care specialists and promotion of advance care directives (presumed to reduce use of expensive and unnecessary end-of-life treatments);
- greater availability of home- and community-based long-term living services and promotion of long-term care insurance;
- smoke-free workplaces, restaurants, and bars, as well as incentives rewarding healthy behaviors;
- expansion of wellness education and access to nutritious foods in public schools; and
- data collection from providers and creation of a consumer-friendly Web site providing information on costs and quality of care and prescription drug costs.

Additional measures to enhance affordability and contain costs include:

- a commission to recommend criteria for determining annual regional and statewide dollar caps on aggregate capital expenditures, based on regional health need and technology assessments;
- adjusted community-rating, rate bands, and a standard of 85 percent or higher loss ratios in the individual and small group insurance markets; and
- greater use of advanced nurse practitioners, midwives, physician assistants, pharmacists, dental hygienists, and other licensed health care providers to both improve access and reduce the cost of care.

Discussion

Many of these quality and efficiency measures proposed and implemented by state policymakers could have public health benefits, which could reduce health cost growth in the long term. But most of the cost containment measures are indirect, and many of them require investments that will increase costs in the short term—such as building information technology infrastructure and providing prevention and disease/care management services. Even in situations where short-term savings are assumed to occur

(e.g., less "free care" provided when uninsurance rate declines), it is difficult to measure and "capture" the savings to pay for other strategies.

States might learn that significant cost containment will require a *national* effort to address the major cost drivers, such as virtually unlimited access to expensive technologies and end-of-life interventions. However, the rising number of multifaceted state-level reform plans reflects a growing understanding among state policymakers that health care access, cost, and quality are interrelated and must be addressed comprehensively.

References

[1] [Prescription For Pennsylvania Changes How We Pay For Health Care To Focus On Improving Quality, Enhancing Patient Safety And Promoting Wellness.](#)

[2] The Vermont Blueprint for Health was launched by Governor Douglas in 2003 and endorsed in 2006 by the General Assembly under Act 191. It has been implemented and is reportedly making good progress in many communities.

[3] A recent report by the Peter Harbage and Len Nichols found that the "hidden tax" is \$1,186 per California family and \$455 for individual health insurance policies. P. Harbage and L. Nichols, [A Premium Price: The Hidden Costs All Californians Pay in Our Fragmented Health Care System](#), (Sacramento, CA: New America Foundation, December 2006).

[4] Premiums are subsidized for lower-income uninsured adults with income up to 300 percent of the federal poverty level and employees of small businesses with below-average wages.

For More Information

See: [Vermont 2006 Health Care Reform Act](#)
[California Governor's Health Care Proposal](#)
[Pennsylvania Governor's Health Care Proposal](#) and [Rx for Quality](#)
National Conference for State Legislatures [2007 Universal Health Care Bills](#)

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Snapshots: Short Takes on New State Initiatives

Delaware Health Information Network: Building a Statewide Data Interchange

In September 2006, Delaware became the first state in the nation to begin building a network to connect all major sources of patient clinical information. Established in 1997 by the Delaware General Assembly, the Delaware Health Information Network (DHIN) is a public-private partnership to advance the creation of a statewide health information and electronic data interchange network for public and private use. The DHIN, which operates under the auspices of the Delaware Health Care Commission, has contracted with Medicity, Inc. to build the network that will ultimately give physicians immediate

electronic access to patients' medical histories. The goal is to give practitioners the technology tools they need to "save lives, reduce medical errors, and manage health care costs...to bring Delaware's health care system into the twenty-first century." [1]

According to Sarah McCloskey at the Delaware Health Care Commission, Phase 1 of the project is set to "go live" by March 30, 2007, for a core group of users. This phase involves development of a network infrastructure and training modules for the transmission of lab results, radiology reports, and admission, discharge, and transfer reports via a secure Web platform. The state hopes to eliminate the current system, by which physicians receive lab and other test results through myriad channels including telephone, fax, courier, and in some cases Web portals. The DHIN will work with providers and allow them to decide how they would prefer to receive their information—via fax, e-mail, or directly into the patient's electronic medical record (EMR)—and then deliver the information in that method in real time. The core group includes three hospital systems (Bayhealth Medical Center, Beebe Medical Center, and Christiana Care Health System), Lab Corp., and five physician practices representing nearly 30 practice sites and 70 physicians.

DHIN officials anticipate that, within six months from the initial launch, there will be significant take-up from data providers (e.g., hospitals, laboratories, and radiology facilities) as well as private physician practices. In Phase 2, the DHIN will develop a record locator system allowing physicians to search for patients' clinical reports and results history. "There is a great deal of interest in the DHIN among the health care community," noted Gina Perez, DHIN's project director.

Future efforts include creation of a patient portal to enable patients to access their health information and see which physicians have accessed their records. The DHIN also will seek to make it easier for providers to submit claims forms to insurance companies through electronic attachments, so that claims can be processed more quickly. Eventually, DHIN hopes to create a system for centralized public health reporting, chronic disease management, and clinical decision support.

The DHIN is being funded by a \$2 million investment from the state, which is being matched by private funding through the three hospital systems, Lab Corp., and Blue Cross Blue Shield of Delaware. In addition, the Delaware Health Care Commission was awarded \$4.7 million from the Agency for Healthcare Research and Quality over five years to develop the DHIN system.

DHIN predicts, that in most cases, providers' investment to access clinical information through DHIN will be as low as the cost of a desktop computer and high-speed internet service. The system has the potential for significant savings to providers, patients, and payers according to Janice Tildon-Burton, M.D., president of the Medical Society of Delaware. Burton notes that having current information in real time will lead to fewer unnecessary tests and more cost-effective care overall.

Reference

[1] "Delaware to Build First Statewide Health Information Network," Press Release, Delaware Health Care Commission, October 4, 2006.

For More Information

Contact: Sarah McCloskey, Delaware Health Care Commission, sarah.mccloskey@state.de.us or Gina Perez, Advances in Management, Inc., gina@aim2bbest.com.

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Pennsylvania's Public Reporting of Hospital-Acquired Infections: How Are Hospitals Addressing the Issue?

In the fall of 2006, the Pennsylvania Health Care Cost Containment Council (PHC4) released a report on the extent and cost of hospital-acquired infections across the state in calendar year 2005. Pennsylvania was the first state to publicly report such information. The findings were stunning: an infection rate of 12.2 per 1,000 hospital cases, leading to over 394,000 infection-related hospital days amounting to hospital charges of \$3.5 billion. According to the report, the average commercial insurance payment related to caring for a patient who acquired an infection in the hospital was almost \$54,000, compared with approximately \$8,000 in commercial insurance payments for each patient who did not acquire an infection.

Efforts to address infection control were already under way at many of the state's hospitals, "but the PHC4 report certainly intensified the national discussion about how to not only reduce, but to eliminate, hospital-acquired infections," according to Joseph Martin, PHC4's director of communications and education. Pennsylvania hospitals have taken dramatic steps to decrease the rate of central line IV-associated sepsis, one of the most common forms of hospital-acquired infection.

For example, in 2005, the Health Care Improvement Foundation created the Partnership for Patient Care, a regional collaborative effort aimed at identifying specific steps that could be taken to reduce infections due to central IV lines. [1] Through the partnership, participating hospitals are addressing all 30 of the National Quality Forum's "safe practices," and in 2006 they showed a 9 percent improvement in meeting infection-prevention goals. [2] Chester County Hospital began using an evidence-based practice [bundle](#) developed by the Institute for Healthcare Improvement, and subsequently reduced its central line-associated infection rate by 25 percent last year. [3] The bundle laid out a protocol for creating an entirely sterile environment for placing a central line, including a head-to-foot patient drape with only a small hole near the shoulder, mandatory head caps for staff placing the line, and use of a special antiseptic. As in other hospital efforts to improve quality, nurses and other staff were trained to halt the process if they were

uncomfortable with the level of sterility.

The University of Pennsylvania hospital, which has approximately 70,000 central line patient days annually, reduced the infection rate by 30 percent between 2005 and 2006.[4] Other hospitals demonstrating leadership in this area include Allegheny General, Butler Memorial Hospital, Charles Cole Memorial, Hamot Medical Center, and Thomas Jefferson University Hospital, according to Martin. For example, through staff training on infection control, Allegheny General Hospital reduced its rate of central line–acquired infections from one infection in every 23 lines placed to one in every 535 lines placed as of the end of February 2006. More than \$2 million and an estimated 47 lives were saved over three years.[5]

There will undoubtedly be more efforts targeting hospital-acquired infections (both central line–associated and otherwise) in the near future, given the recent health care proposal put forth by Governor Rendell. The 47-point proposal advocates for the use of financial incentives (e.g., bonuses based on hospital performance, eventual discontinuation of state payments related to hospital-acquired infections) to reduce hospital-acquired infections.

References

[1] The Health Care Improvement Foundation is part of the Delaware Valley Health Care Council.

[2] [Partnership for Patient Care: First Year Assessment](#).

[3] Josh Goldstein, "Area Hospitals Push to Stem IV Infections," *The Philadelphia Inquirer*, February 22, 2007.

[4] Ibid.

[5] See: R. Shannon, [Testimony before the U.S. House Energy and Commerce Subcommittee on Oversight and Investigations](#), March 29, 2006; U.S. House of Representatives, Rx: Health Care Reform FYI #48 Subject: [Healthier Hospitals: Eliminating Preventable Healthcare-Associated Infections](#). From: Rep. Tim Murphy (PA-18).

For More Information

Contact: Joe Martin, director of communications and education, Pennsylvania Health Care Cost Containment Council, jmartin@phc4.org.

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Washington Medicaid Integration Partnership: Integrating Physical and Behavioral Services for Improved Outcomes

To address quality issues and potentially reduce spending in the long term, some state Medicaid programs are creating programs to integrate physical and behavioral health services. Studies show that chronically ill patients with behavioral comorbidities, such as

substance abuse or mental health problems, tend to experience significantly higher medical costs than those without, and that treating these mental health and substance abuse issues can lower health care costs for these patients overall.[1] One established program, the Washington Medicaid Integration Partnership (WMIP), has already documented success.

Washington State defines service integration as "bringing different Medicaid-funded health care services together in a coordinated, client-centered framework" to improve patient services and satisfaction.[2] [The WMIP](#) is a demonstration project that began in January 2005 and is currently serving 2,700 Medicaid enrollees who are eligible for supplemental security income (SSI) in Snohomish County.[3] The goal of WMIP is to integrate managed care services in mental health, drug and chemical dependency treatment, and medical care.

A recent evaluation conducted by the Department of Social and Health Services (DSHS), with support from the [Center for Health Care Strategies](#), found that 40 percent of patients included in this demonstration felt their care was better coordinated than before enrolling with WMIP's managed care contractor, Molina Healthcare of Washington. In addition, 24 percent reported that services provided by the health plan improved in that there were fewer delays while waiting for approval for care, shorter waiting times for appointments for routine care, and better customer service and less paperwork. It should be noted that 7 percent of clients thought their care coordination had declined. Levels of reported satisfaction with Molina were lower in terms of accessing assistance by phone during office hours, getting help for an injury or condition that required immediate care, and prescription drug coverage.

DSHS estimates that the state reaps significant savings from integrating services. A recent DSHS study found that, by integrating mental health treatment with medical care, up to 50 percent of the cost of such treatment was offset. Adding psychotropic medication into the mix offset costs by up to 64 percent.[4]

According to Alice Lind, WMIP program manager, there has been some interest by other counties in becoming demonstration sites, based on the success in Snohomish County. Additional counties may be added in 2008.

References

[1] Olsson, M., et al., [Mental Health/Medical Care Offsets: Opportunities for Managed Care](#), *Health Affairs* March/April 1999, 18:2.

[2] [Innovative Medicaid Integration Pilot Project Shows Improvement Over Two Years](#), DSHS press release, January 26, 2007.

[3] The demonstration is budgeted to enroll up to 6,000 individuals. Outreach efforts are being conducted to increase enrollment, including auto-enrollment and mailings to dual Medicaid-Medicare eligibles.

[4] "Integration of Medicaid Services to Improve Health Outcomes," DSHS Fact Sheet, January 2007.

For More Information

Contact: Alice Lind, WMIP Program Manager, lindar@dshs.wa.gov.

See: S. B. Perlman and R. H. Dougherty, [State Behavioral Health Innovations: Disseminating Promising Practices](#), The Commonwealth Fund, August 2006

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Michigan: Promoting Wellness in Private Insurance

Michigan recently enacted legislation intended to "promote the availability of health behavior wellness, maintenance, and improvement programs" in private insurance. [1] The insurance code was amended to allow group health plans and insurance carriers to give premium rebates of up to 10 percent if workers or members participate in group wellness programs. Individuals and families are also eligible for reduced cost-sharing if they commit to healthier lifestyles.

Michigan joins Vermont and Rhode Island in leading state efforts to encourage private health plans to emphasize prevention and wellness. Vermont allows insurers to offer "Healthy Lifestyles" discounts of up to 15 percent of premium for compliance with a health promotion program. Rhode Island is promoting healthy lifestyles in private insurance through its [wellness health benefit plan](#). And California Governor Schwarzenegger's health reform proposal features incentive and reward programs, including premium reduction, for engaging in healthy activities (see Profile in this issue).

Michigan's Blue Care Network (BCN), a subsidiary of Blue Cross Blue Shield of Michigan, recently began offering a wellness plan to small and large businesses across the state. For example, the plan is being offered through the Detroit Regional Chamber.[2] Under the rationale that responsible behaviors should cost less, "Healthy Blue Living" rewards members who commit to healthier lifestyles with lower out-of-pocket costs. Employers choosing this option pay reduced premiums (by about 10 percent), and members face lower copayments and deductibles during the first 90 days of coverage. The reduced cost-sharing continues if a member:

- completes a health risk appraisal, after which BCN sends a detailed profile with tips on how to minimize risks;
- meets with his or her primary care physician to complete and submit a qualification form, which involves developing a wellness plan whereby the member and physician set targets and monitor progress; and
- adopts a healthy lifestyle by focusing on six high-impact health measures for which the member has some control (alcohol use, blood pressure, blood sugar, cholesterol, smoking, and weight).

To help reach their health goals, members have access to a health coach, smoking cessation programs, YMCAs, Weight Watchers' discounts, and other benefits.

References

[1] Michigan Senate Bill 848.

[2] For more information see [Michigan Blue Network Web site](#) and [Detroit Regional Chamber Web site](#).

For More Information

See: Michigan Legislature, [Insurance Code of 1956, Act 218](#)

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Federal Support for States

Medicaid Transformation Grants

The Deficit Reduction Act authorizes the federal government to grant states a total of \$150 million in "Medicaid Transformation Grants" (MTGs) over two years for the "adoption of innovative methods to improve effectiveness and efficiency in providing medical assistance under [Medicaid]." [1] The Centers for Medicare and Medicaid Services (CMS) announced awards totaling \$103 million on January 25, 2007, and there will be a second grant solicitation for the remaining \$47 million. Thirty-three grants, averaging \$3.1 million, were awarded to 27 states and the District of Columbia (a few states applied for and received more than one grant). The grants range from \$75,000, for North Dakota, to \$9.9 million for the District of Columbia. Each grant is divided into FY 2007 and FY 2008 allocations.

The majority of states are using the grants to design, develop, and/or implement health information technology (HIT) in a range of areas related to their Medicaid programs. Following is one way to categorize the grant activities: [2]

Focus of Grant	Number of Grants	State Grantees
Electronic medical records or health information systems and exchanges	13	AL, AZ, DC, HI, KY, MI, MN, MT, NM, TX, WV (2), WI
Pharmacy HIT tools	7	CT, FL, NM, ND, TN, UT, WV
Electronic verification of citizenship	4	AR, MA, MI, RI

Promoting good health and personal responsibility	2	WV (2)
Predictive modeling system	2	IL, KS
Program integrity (fraud reduction)	2	MD, NY
Medical information for children	1	NJ
Health provider credentialing	1	MI
Medicaid estate recovery	1	IN

Below we summarize a few of the states' grant activities. Full applications can be viewed on the [CMS Web site](#).

Wisconsin's grant (\$3.0 m) will be used to create a regional health information exchange framework, infrastructure, and system to enable multiple hospitals, clinics, and health care institutions to rapidly and securely access medical history information about patients enrolled in Medicaid and General Assistance Medical Programs in Milwaukee County. Access to patients' medical histories across health care providers should help reduce redundant tests and procedures, improve health care outcomes, and reduce health care costs.

Utah's grant (\$2.9 m) will help refine and implement a Pharmacotherapy Risk Management System (Utah ePRM). This electronic surveillance tool will support medication therapy, risk management services, and innovative multifaceted interventions. It will be used to identify potential drug therapy problems, select patients and providers for in-depth clinical reviews and intervention, identify potential fraud and diversion of controlled substances, and track patterns of medication.

One of **West Virginia's** five grants (\$3.9 m) will be used to help transform the primary care delivery system into a network of connected regional "Advanced Medical Homes" (AMHs) for Medicaid beneficiaries. The AMHs will utilize the [chronic care model](#) in providing proactive, patient-centered preventive and chronic disease care. An interactive electronic health management system with clinical reminders, patient education, and risk stratification tools is expected to help Medicaid members meet personal responsibility guidelines and health self-management goals. The AMHs will eventually be connected to the Medicaid data warehouse, promoting predictive modeling and population-based health management.

Kansas will use its grant (\$0.9 m) to equip certain case managers with "Impact Pro," a computerized, predictive modeling tool that will help them monitor chronic conditions and improve preventive care. The tool uses Medicaid claims data to alert case managers to needed screenings and preventive care opportunities. The pilot program will invite case managers from selected Community Developmental Disability Organizations and

Community Mental Health Centers to participate.

According to CMS spokesperson Mary Kahn, "the goal of the Medicaid Transformation Grants is to allow states a new level of participation in designing their Medicaid programs to fit the needs of their various populations." All of the Medicaid Transformation Grants incorporate an evaluation component to assess the impact of the innovations developed and implemented.

References

[1] Public Law 109-171 Section 6081,

<http://www.cms.hhs.gov/MedicaidTransGrants/Downloads/6081.pdf>.

[2] Categories based on initial review by Patricia MacTaggart, Health Management Associates.

For More Information

Contact: Center for Medicaid and State Operations, (410) 786-3870.

See: [CMS Web site](#)

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Commission Corner

The Commonwealth Fund's Commission on a High Performance Health System continues to strive for increased access, quality, and efficiency in the U.S. health care system. To this end, the Commission co-sponsored with the Alliance for Health Reform its 2007 Bipartisan Congressional Health Policy Conference, an annual retreat for members of Congress to learn about critical issues in health policy, in January. Attended by members of the House of Representatives and the United States Senate, the retreat facilitated honest and open discussion between principal decision-makers on such crucial topics as reauthorization of the State Children's Health Insurance Program (SCHIP), public reporting and transparency, lessons from abroad, and state innovations. In February, the Commission co-sponsored with the Alliance for Health Reform and the Catholic Health Association a retreat for Congressional staffers in D.C., addressing similar issues.

The Commission has also released two Data Briefs since January: "[Health Care Opinion Leaders' Views on Priorities for the New Congress](#)" highlights the perspectives of a diverse group of experts on what the health care priorities for the 110th Congress should be, and "[The Agency for Healthcare Research and Quality's 2006 National Healthcare Quality Report](#)" addresses rates of improvement across measures of quality in U.S. health care.

In March, the Commission and the Alliance for Health Reform sponsored two briefings designed for individuals working on or interested in federal health policy. [The first](#)

focused on the upcoming reauthorization and potential reform of the State Children's Health Insurance Program (SCHIP) and the second, to be released next week, addressed current proposals for expanding health insurance coverage.

In San Francisco at the end of March, the Commission will conduct the first of its three meetings of 2007. The members will visit Kaiser Permanente's San Francisco Medical Center to observe pioneering initiatives in health care organization and delivery and discuss how the lessons learned there can be translated to the U.S. health care system as a whole.

For more information, please visit the [Commission on a High Performance Health System page](#).

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Related Publications

T. Brennan, L. Reisman, [Value-based Insurance Design and the Next Generation of Consumer-Driven Health Care](#), *Health Affairs* (Millwood), Mar./Apr. 2007 26(2):w204–7. Epub 2007 Jan 30.

J.P. Clement, R.C. Lindrooth, A.S. Chukmaitov, H.F. Chen, [Does the Patient's Payer Matter in Hospital Patient Safety?: A Study of Urban Hospitals](#), *Medical Care*, Feb. 2007 45(2):131–8.

K. Davis, [Uninsured in America: Problems and Possible Solutions](#), *BMJ*, Feb. 17 2007 334(7589):346–8.

J.D. Dunn, [Pharmacy Management Approach: How Do We Align All the Incentives?](#), *Journal of Managed Care Pharmacy*, Mar. 2007 13(2 Suppl B):16–8.

P.K. Lindenauer, D. Remus, S. Roman et al., [Public Reporting and Pay for Performance in Hospital Quality Improvement](#), *New England Journal of Medicine*, Feb. 1, 2007 356(5):486–96. Epub 2007 Jan 26.

K. Mattock, K. Lalime, J.P. Tate et al., [The State of Physician Office-based Health Information Technology in Connecticut: Current Use, Barriers, and Future Plans](#), *Connecticut Med.*, Jan. 2007 71(1):27–31.

L. Shi, P.B. Collins, K.F. Aaron et al. [Health Center Financial Performance: National Trends and State Variation, 1998-2004](#), *J Public Health Manag Pract.* Mar./Apr. 2007 13(2):133–150.

Commonwealth Fund Publications

A. Burton, I. Friedenzohn, and E. Martinez-Vidal, [State Strategies to Expand Health Insurance Coverage: Trends and Lessons for Policymakers](#), The Commonwealth Fund, February 2007.

S. R. Collins, K. Davis, and J. L. Kriss, [An Analysis of Leading Congressional Health Care Bills, 2005-2007: Part I Insurance Coverage](#), The Commonwealth Fund, March 2007.

J. M. Colmers, [Public Reporting and Transparency](#), The Commonwealth Fund, February 2007.

K. Davis, C. Schoen, S. Guterman, T. Shih, S. C. Schoenbaum, and I. Weinbaum, [Slowing the Growth of U.S. Health Care Expenditures: What Are the Options?](#), The Commonwealth Fund, January 2007.

J. M. Lambrew, [The State Children's Health Insurance Program: Past, Present, and Future](#), The Commonwealth Fund, February 2007.

J. Rizzo, K. Fox, T. Trail et al., [State Pharmacy Assistance Programs: A Chartbook—Updated and Revised](#), The Commonwealth Fund, January 2007.

S. C. Schoenbaum, D. McCarthy, and C. Schoen, [The Agency for Healthcare Research and Quality's 2006 National Healthcare Quality Report](#), The Commonwealth Fund, March 2007.

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Upcoming Meetings

International Forum on Quality and Safety in Health Care 2007
Barcelona, Spain
April 18–20, 2007
www.ihf.org/IHI/

National Conference of State Legislatures (NCSL) Spring Forum 2007
Washington, DC
April 19–21, 2007
<http://ncsl.org/forum/>

AcademyHealth Annual Research Meeting
Orlando, FL
June 3–5, 2007
www.academyhealth.org/

NCSL Annual Meeting
Boston, MA
August 5–9, 2007
<http://ncsl.org/annualmeeting/>

National Academy of State Health Policy's Annual State Health Policy Conference
Denver, CO
October 14–16, 2007
<http://nashp.org/>

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The *States in Action* bimonthly newsletter describes innovative state health programs from across the country. It is intended to help policymakers, administrators, and researchers as they work to stretch health care dollars and meet the needs of their residents.

States in Action is part of a Commonwealth Fund [program on state innovations](#). For more information, contact Rachel Nuzum, Program Officer, State Innovations at rn@cmwf.org

We welcome those involved in state efforts to expand coverage and improve care and efficiency to send an e-mail about their efforts to stateinnovations@cmwf.org.

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