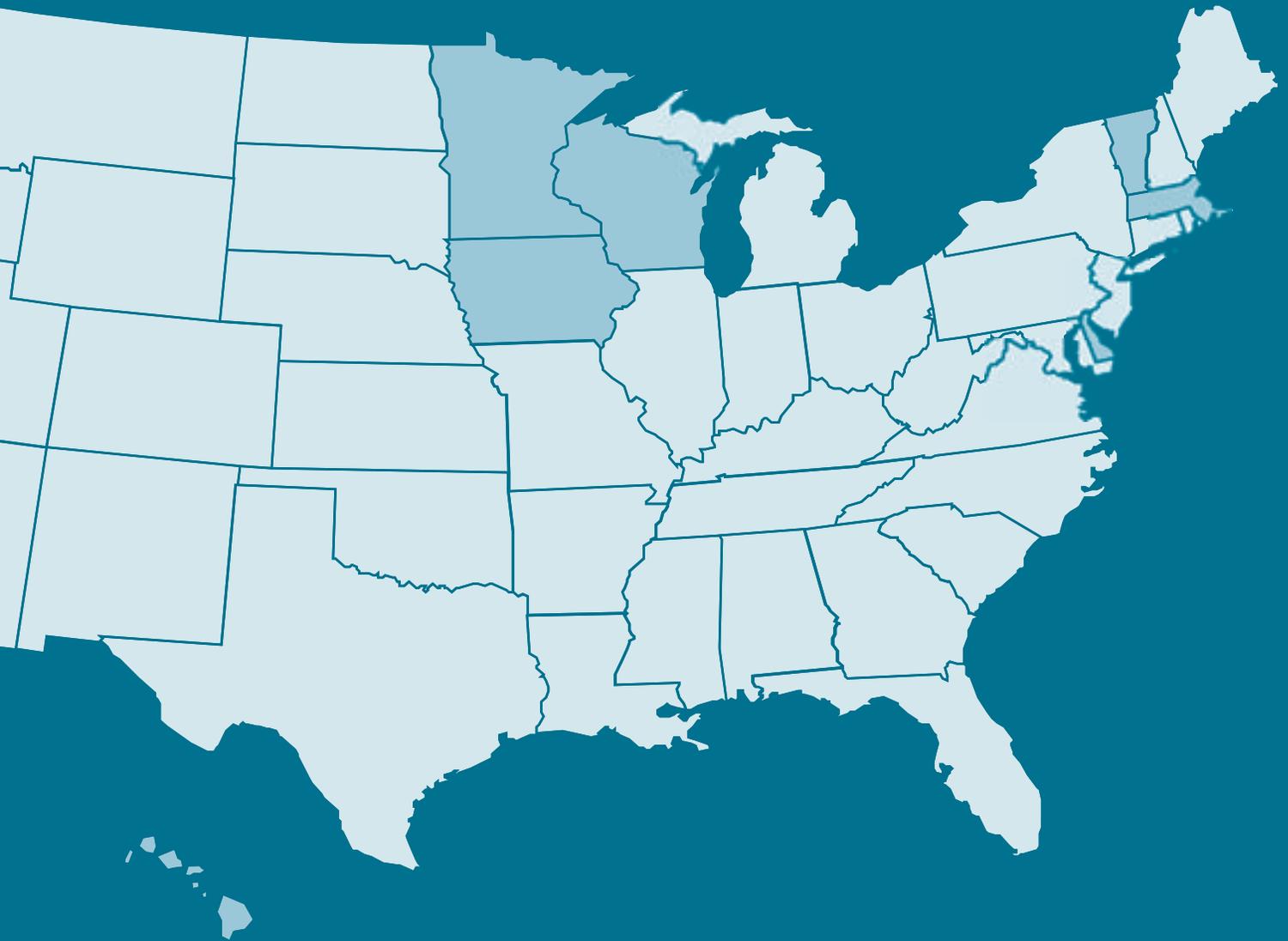


AIMING HIGHER FOR HEALTH SYSTEM PERFORMANCE

A Profile of Seven States That Perform Well on
the Commonwealth Fund's 2009 State Scorecard



OCTOBER 2009



THE COMMONWEALTH FUND

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Aiming Higher for Health System Performance: *A Profile of Seven States That Perform Well on the Commonwealth Fund's 2009 State Scorecard*

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OCTOBER 2009

ABSTRACT: As a companion to the 2009 *State Scorecard*, this report profiles seven health systems: six that rank among the top quartile of states—Vermont, Hawaii, Iowa, Minnesota, Massachusetts, and Wisconsin—plus Delaware, which was among the most-improved states from 2007 to 2009. These states demonstrate that high levels of health system performance are achievable and sustainable, and provide useful examples of state policies and practices that may be reasonably associated with health system improvement: a long-term commitment to reform, collaboration among stakeholders, leadership to expand health insurance coverage, transparency of health information, and a capacity to act on emerging best practices. The *State Scorecard* and this report also show that all states can aim higher in health system performance: if all states improved performance to the levels achieved by the best states, then thousands of lives could be saved and significant cost savings and improved health outcomes could be achieved.

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* “High-Performing States” ranked in the top quartile of states on the Commonwealth Fund State Scorecard on Health System Performance, 2009. “Most-Improving States” had substantial (5 percent or greater) improvement on half or more of the State Scorecard’s indicators with trends. Delaware and two other states (Arkansas and West Virginia) plus the District of Columbia met this criterion.

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OVERVIEW

The 2009 edition of The Commonwealth Fund's *State Scorecard on Health System Performance* identifies wide variation across states in numerous indicators related to access, quality, avoidable hospital use and costs, and healthy lives. *State Scorecard* findings suggest that if middle- and low-performing states were to implement strategies and policies to help bring them to the levels of the highest-performing states, significant cost savings and improved health outcomes could be achieved.

As a companion to the 2009 *State Scorecard*, this report profiles seven state health systems: six that rank among the top quartile of states—Vermont, Hawaii, Iowa, Minnesota, Massachusetts, and Wisconsin—plus Delaware, which was one of the most-improved states (achieving improvement of 5 percent or greater on at least half the scorecard's indicators) from 2007 to 2009. The six leading states also improved substantially since the 2007 *State Scorecard* on many indicators of performance.

In general, the states that ranked in the top quartile in the 2007 *State Scorecard* remain the leaders in 2009, outperforming their peers on multiple indicators (Table 1).¹ These patterns and the findings from the state profiles indicate that public policies plus state and local health care systems can make a difference. Vermont and Massachusetts, for example, have enacted comprehensive reforms to expand coverage and put in place initiatives to improve population health and benchmark providers on quality. Minnesota is a leader in bringing public- and private-sector stakeholders together in collaborative initiatives to improve the overall value of health care—an approach that is gaining traction in other states.

The challenge for all states and for all private-sector health care delivery systems is to learn to use health care resources more effectively and efficiently,

in order to realize greater value and greater gains in outcomes. The goal of this report is to showcase insights from high-performing states and identify opportunities for all states to pursue policies and practices that may be reasonably associated with high performance.

Affordable Coverage for All

The seven states profiled in this report have a long history of health system improvement focused on expanding health insurance coverage for uninsured residents. Most experts in these states credit health reforms enacted in the early 1990s as setting the stage for recent coverage expansions and quality gains. All seven profiled states, for example, made significant, early gains in coverage by extending Medicaid benefits to otherwise uninsured residents. The authority for these expansions was granted by the federal government through Medicaid 1115 demonstration waivers and, in most cases, included significant federal financial support.

Health system improvement does not come all at once, but is accumulated over years, sometimes decades, one layer of success building on another. States that want to replicate Massachusetts' precedent setting 2006 reforms, for example, must first understand that earlier reforms in 1985, 1988, 1991, 1996, and 1997 were necessary to put the 2006 reforms within reach. Change on this scale requires persistent focus: the complexities of health care and its many dysfunctions, say the veterans of reform, require ongoing and comprehensive solutions to expand access, improve quality, and control costs.

Shared Values Drive Collaboration

Policymakers in the seven profiled states credit their states' "culture of collaboration" as the critical driver in health system performance. "We trust each other,"

they say, or “We work through our differences to do what is right.” In some states, this process is well-organized, like Vermont’s Blueprint for Health. In others, like Minnesota, change emerges dynamically from “coalitions of coalitions.” But leaders in all of the high-performing states are quick to name the values that set the terms of collaboration—a progressive political tradition in Massachusetts, a commitment to public health in Vermont, an agricultural work ethic in Iowa, and in Delaware it is simply “The Delaware Way.”

A Firm Foundation of Transparency and Innovation

States with high-performing health systems have a number of state policies and practices in common. In addition to expanding coverage, recent health reforms in the profiled states have focused on increasing value by improving quality and controlling costs. The most important strategy has been to make health information transparent to consumers and purchasers. The *State Scorecard* documents widespread improvement on selected indicators, especially quality indicators for which there has been a national commitment to reporting performance data and collaborative efforts to improve.

Most of the profiled states support a stand-alone organization with a specific mission to collect and publicly report cost and quality information.² In many cases, these organizations were established by physician leaders or hospital systems to improve patient care and today function as a multi-stakeholder forum to align statewide quality improvement and cost control initiatives. These organizations are “on call” to evaluate and adopt emerging best practices, and have put the profiled states among the nation’s leaders in establishing patient-centered medical homes, exchanging health information

electronically, and experimenting with payment reforms that reward health professionals for the quality rather than the quantity of services provided.

Aiming Higher: A Congruent Set of Policies

States with high-performing health systems work hard to establish a congruent set of policies that make the most of both state and federal resources. States play many roles in the health system: purchasers of coverage for vulnerable populations and their employees; regulators of providers and insurers; advocates for public health; and, increasingly, conveners of and collaborators with other health system stakeholders. State action is also key to improving primary care infrastructures and community-wide systems that facilitate access, improve coordination, and promote effective care.

The seven states profiled in this report show that very high levels of health system performance are achievable and sustainable. Vermont, Hawaii, Iowa, Minnesota, Massachusetts, Wisconsin, and Delaware provide useful and interesting examples of state policies and practices that may be reasonably associated with health system improvement. Across these states, there are common strategies that others may consider: a long-term commitment to reform, encouraging collaboration among multiple stakeholders, leadership to expand health insurance coverage through public programs, transparency of health information, and making sure the state has the capacity to recognize and act on emerging best practices.

Delivery system characteristics also may play a role in supporting an infrastructure of improvement in higher-performing states. The seven states tend to have a greater proportion of hospitals that are part of integrated systems, and their community hospitals are predominantly nonprofit or government-owned (Table 2). Health plan enrollment tends to be more

Table 1. State Scorecard Results: High Performing and Most-Improved States^a

PERFORMANCE SUMMARY

Overall Scorecard Rank
 Number of Indicators in Top Quartile
 Number of Indicators in Top 5 States
 Number of Indicators Improved by 5% or More

PERFORMANCE ON SCORECARD INDICATORS

Access

Nonelderly adults (ages 18–64) insured
 Children (ages 0–17) insured
 At-risk adults visited a doctor for routine checkup in the past two years
 Adults without a time in the past year when they needed to see a doctor but could not because of cost

Prevention and Treatment

Adults age 50 and older received recommended screening and preventive care
 Adult diabetics received recommended preventive care
 Children ages 19–35 months received all recommended doses of five key vaccines
 Children with both a medical and dental preventive care visit in the past year
 Children who received needed mental health care in the past year
 Hospitalized patients received recommended care for heart attack, heart failure, and pneumonia
 Surgical patients received appropriate care to prevent complications
 Home health patients who get better at walking or moving around
 Adults with a usual source of care
 Children with a medical home
 Heart failure patients given written instructions at discharge
 Medicare patients whose health care provider always listens, explains, shows respect, and spends enough time with them
 Medicare patients giving a best rating for health care received in the past year
 High-risk nursing home residents with pressure sores
 Long-stay nursing home residents who were physically restrained
 Long-stay nursing home residents who have moderate to severe pain

Avoidable Use and Cost

Hospital admissions for pediatric asthma per 100,000 children
 Adult asthmatics with an emergency room or urgent care visit in the past year
 Medicare hospital admissions for ambulatory care sensitive conditions per 100,000 beneficiaries
 Medicare 30-day hospital readmissions as a percent of admissions
 Long-stay nursing home residents with a hospital admission
 Short-stay nursing home residents with hospital readmission within 30 days
 Home health patients with a hospital admission
 Hospital Care Intensity Index (US=1.0 in 2002)^b
 Total single premium per enrolled employee at private-sector establishments that offer health insurance
 Total Medicare (Parts A & B) reimbursements per enrollee

	Vermont		Hawaii		Iowa		Minnesota		Massachusetts		Wisconsin		Delaware	
	1		2		2		4		7		10		14	
	22		22		21		25		14		15		13	
	8		14		11		11		11		5		8	
	14		15		14		15		14		14		17	

	US Rate	Vermont		Hawaii		Iowa		Minnesota		Massachusetts		Wisconsin		Delaware	
		Rate	Rank	Rate	Rank	Rate	Rank	Rate	Rank	Rate	Rank	Rate	Rank	Rate	Rank

	80.0	86.5	10	89.4	2	87.2	6	89.2	3	92.8	1	88.1	4	85.7	12
	89.6	93.4	15	94.9	4	95.0	2	93.5	13	96.8	1	94.2	11	91.7	22
	84.6	84.4	25	84.0	27	85.6	20	88.7	6	91.3	3	84.8	22	91.8	2
	86.6	89.9	16	93.1	1	92.2	4	90.9	7	92.7	2	91.5	5	90.7	9

	42.3	49.3	8	41.4	28	42.9	23	50.8	3	49.5	7	45.3	16	52.5	1
	44.3	55.3	2	49.3	10	48.7	12	66.9	1	na	na	54.3	4	49.0	11
	80.1	79.8	30	87.8	4	80.0	27	84.7	7	83.9	8	79.4	32	81.8	13
	71.6	79.4	7	80.3	6	75.4	13	67.5	38	82.6	2	68.2	35	72.7	20
	60.0	69.3	13	62.8	28	74.5	5	67.0	17	66.6	19	61.4	34	76.9	3
	91.3	94.5	6	87.5	50	94.9	4	93.3	14	91.8	25	93.6	9	92.4	21
	84.6	91.0	3	78.3	51	86.8	20	88.2	12	90.3	6	90.2	7	87.0	17
	40.3	38.8	35	40.5	26	34.8	48	33.8	50	40.9	23	37.9	41	37.3	44
	79.7	86.8	6	85.9	8	84.6	12	78.1	34	88.5	4	85.2	10	89.0	1
	57.5	67.2	3	60.1	27	66.9	4	63.0	14	66.2	5	62.9	16	59.9	28
	74.7	82.3	7	65.4	48	81.6	8	76.6	21	75.1	26	76.2	23	84.2	5
	na	74.5	24	77.4	4	74.5	24	77.4	4	75.1	13	75.1	13	78.0	1
	na	61.5	21	66.0	6	67.6	3	66.4	4	62.5	17	65.0	9	69.3	1
	12.0	9.4	11	7.6	3	8.0	5	7.7	4	10.9	22	10.1	16	12.3	37
	5.1	2.4	15	2.9	19	1.8	5	2.3	14	4.7	32	1.8	5	1.5	1
	4.4	3.6	14	2.2	3	4.7	30	3.6	14	2.5	4	3.9	19	4.0	21

	164.9	50.2	2	81.0	4	81.0	4	102.2	9	125.5	18	109.1	12	na	na
	17.6	12.4	5	13.1	8	12.3	4	12.6	7	13.7	10	14.5	11	21.6	33
	6,587	4,963	12	4,144	3	5,981	20	4,749	8	7,262	39	5,872	18	5,427	15
	18.4	14.4	6	16.6	15	15.9	10	16.6	15	19.4	37	16.2	12	20.6	45
	19.9	11.3	6	na	na	16.7	21	6.9	1	14.8	17	13.8	12	19.6	27
	21.2	14.3	2	na	na	18.3	17	17.6	14	19.5	21	17.7	15	23.0	39
	31.9	30.0	31	23.5	6	36.1	45	32.7	37	34.1	40	27.7	20	27.3	19
	1.020	0.652	9	1.051	39	0.753	17	0.697	10	0.962	27	0.719	12	1.091	41
	\$4,386	\$4,900	47	\$3,831	2	\$4,146	14	\$4,432	31	\$4,836	44	\$4,777	42	\$4,733	40
	\$8,304	\$7,284	17	\$5,311	1	\$6,572	7	\$6,600	9	\$9,379	47	\$6,978	15	\$7,646	25

Table 1. State Scorecard Results: High Performing and Most-Improved States^a (continued)

PERFORMANCE ON SCORECARD INDICATORS
Healthy Lives
Mortality amenable to health care, deaths per 100,000 population
Infant mortality, deaths per 1,000 live births
Breast cancer deaths per 100,000 female population
Colorectal cancer deaths per 100,000 population
Suicide deaths per 100,000 population
Nonelderly adults (ages 18–64) limited in any activities because of physical, mental, or emotional problems
Adults who smoke
Children ages 10–17 who are overweight or obese

^a States are shown in order of their ranking on the 2009 *State Scorecard*. Delaware is an example of a state with the most improved performance.

^b Based on inpatient days and inpatient visits among chronically ill Medicare beneficiaries in last two years of life.

na=not applicable, data value is missing.

Notes: All rates are expressed as percentages unless labeled otherwise. See Appendix B in the State Scorecard Report for data year, source, and definition of each indicator.

Source: Commonwealth Fund 2009 *State Scorecard on Health System Performance*

Table 2. A Snapshot of States with High Performing Health Systems*

Demographics
Resident population in millions, 2008 (a)
Median household income, 2005–2007
Percent of population with income below 200% of federal poverty level, 2006–2007
Health Status
Cancer incidence, age-adjusted rate per 100,000, 2004
Percent of adults who are overweight or obese, 2008
Adult self-reported current asthma prevalence rate, 2007
Percent of adults ever told by a doctor that they have diabetes, 2008
Delivery System Characteristics
Percent of community hospitals that are part of highly integrated systems, 2008 (b)
Percent of community hospitals that are nonprofit or owned by state/local government, 2007 (d)
Market share of top two insurers (percent of commercial HMO/PPO members), 2006 (c)

*States are shown in order of their ranking on the Commonwealth Fund *State Scorecard on Health System Performance*, 2009. Delaware is an example of a state with the most improved performance.

(a) US Census Bureau Resident Population, July 2008: <http://www.census.gov/compendia/statab/ranks/rank01.html>.

(b) SDI data reported in the Sanofi Aventis Managed Care Digest Series, Hospital/Systems Digest, 2009. Highly integrated systems either own or contract with three or more components of health care delivery including at least one acute-care hospital, at least one physician component, and at least one other component such as a health maintenance organization (HMO), nursing home, home health agency, or surgery center. They also have at least one systemwide contract with a payer (e.g., employer, HMO or government entity). Hospitals include short-term, acute-care, nonfederal hospitals in the SDI database.

(c) American Medical Association, Competition in Health Insurance, 2007.

(d) Kaiser State Health Facts: <http://statehealthfacts.org/comparebar.jsp?ind=383&cat=8>. Community hospitals include nonfederal, short-term general and specialty hospitals whose facilities and services are available to the public. Excludes long term care hospitals, psychiatric hospitals, institutions for the mentally retarded, and alcoholism and other chemical dependency hospitals.

All other data from The Commonwealth Fund *State Scorecard for Health System Performance*, 2009, Exhibit A16.

	US		Vermont		Hawaii		Iowa		Minnesota		Massachusetts		Wisconsin		Delaware	
	Rate		Rate	Rank	Rate	Rank	Rate	Rank	Rate	Rank	Rate	Rank	Rate	Rank	Rate	Rank
	95.6		68.0	3	79.8	19	79.1	18	63.9	1	78.0	17	77.7	15	96.7	30
	6.9		6.5	19	6.6	23	5.4	8	5.1	2	5.1	2	6.5	19	9.0	46
	24.1		20.4	4	19.0	2	21.1	6	22.4	12	23.2	20	22.6	15	23.6	24
	17.5		17.6	22	14.5	3	18.2	29	14.8	4	17.6	22	16.3	11	17.9	27
	10.9		12.2	28	8.3	7	10.9	16	10.3	12	7.2	5	11.5	22	9.6	11
	16.9		17.2	28	12.9	2	14.1	3	15.0	11	16.1	20	14.2	5	18.9	38
	19.4		17.7	12	17.2	6	20.6	33	17.4	8	17.0	5	20.1	26	20.3	29
	31.7		26.8	9	28.5	15	26.5	8	23.1	1	30.1	22	27.9	12	33.1	35

	US		Vermont		Hawaii		Iowa		Minnesota		Massachusetts		Wisconsin		Delaware*	
	Amount		Amount	Rank	Amount	Rank	Amount	Rank	Amount	Rank	Amount	Rank	Amount	Rank	Amount	Rank
	304.1		0.6	49	1.3	42	3.0	30	5.2	21	6.5	14	5.6	20	0.9	45
	\$49,901		\$51,566	17	\$63,164	4	\$49,262	24	\$57,815	8	\$58,286	7	\$50,619	19	\$54,310	14
	35.8		29.2	9	33.4	24	29.4	10	27.7	4	31.1	14	29.9	12	31.5	17
	458.2		477.3	36	423.6	4	467.0	31	490.5	43	501.7	48	443.1	10	487.5	41
	63.0		58.4	6	57.3	3	64.2	33	62.7	23	58.0	4	63.5	28	63.6	30
	8.2		9.6	46	8.0	17	7.0	5	7.7	11	9.9	48	9.2	39	7.8	13
	8.2		6.4	4	8.2	25	7.0	11	5.9	1	7.1	13	7.2	14	8.2	25
	38.0		46.7	14	22.7	43	28.8	41	47.8	13	46.3	15	59.5	5	50.0	9
	82.2		100.0	1	100.0	1	100.0	1	100.0	1	89.7	21	96.0	13	100.0	1
	36		90	13	98	1	80	5	76	7	67	16	62	32	65	27

concentrated among top plans in the seven states and, while this may limit competition, it also may facilitate efforts to develop coordinated strategies for improvement.

While leading states such as Massachusetts, Minnesota, and Vermont have enacted policy reforms that are extending coverage, promoting community health, and building value-based purchasing strategies through public–private collaboration, this has not been the case in the vast majority of states. In addition to their willingness to persevere in pursuing reforms, some high-performing states may be advantaged by greater resources to support their efforts. A few of the seven profiled states have higher median incomes and lower poverty levels than the national average, while others are closer to the national average (Table 2). Health status exhibits a somewhat mixed picture of higher and lower rates of reported disease prevalence or risk factors both within and across the states profiled.

Lower-performing states, especially states in the bottom quartile, are often challenged by higher rates of disease and poverty, plus high uninsured rates reflecting historic patterns of low employment-based health benefits. Where a large proportion of the population is uninsured, states face a much higher hurdle

in seeking to enact comprehensive reform. These historic and geographic disparities across states point to the importance of federal action to raise the floor across all states and create a supportive climate for state innovation and achievement. Encouraging the adoption of systemic improvements will likely require Medicare’s participation in state payment initiatives and will require collaborative federal and state efforts to develop the information and shared resources infrastructure necessary to achieve high performance.

The *State Scorecard* shows that all states can aim higher in their health system performance. With rising costs putting pressure on families and businesses alike, it is urgent that states and the federal government join together to take action to enhance value in the health care system and ensure that everyone has the opportunity to participate in it fully. Improving the performance of all states to the levels achieved by the best states could save thousands of lives, improve access and quality of life for millions of people, and reduce costs. In turn, this would free up funds to pay for improved care and expanded insurance coverage—producing a net gain in value from a higher-performing health care system.

**AIMING HIGHER FOR HEALTH
SYSTEM PERFORMANCE:
A PROFILE OF SEVEN STATES THAT
PERFORM WELL ON THE
COMMONWEALTH FUND'S 2009
STATE SCORECARD**

**VERMONT: A BLUEPRINT TO CONTROL COSTS
AND EXPAND COVERAGE**

Vermont ranks at the top of The Commonwealth Fund's *State Scorecard on Health System Performance, 2009*. It is the only state that ranks in the top quartile of states across all five dimensions of performance measured by the *State Scorecard*. The state is a leader in integrating public health principles into the health care delivery system, and has one of the most innovative models of prevention and care coordination in the country. The goal of these activities is to shift the focus of health care from only treating illness to a system that prioritizes prevention, supports healthy environments and lifestyles, and improves access to preventive and primary care. The scorecard indicates the strategy is working—Vermont continues to improve its already-high rankings in prevention and treatment, and other measures of healthy lives, and to hold the line on cost (Table 3).

Since 2003, Vermont's health system performance has been driven by a "Blueprint for Health," initiated by Gov. Jim Douglas (R) and the health commissioner at the time, Paul Jarris, M.D., to cut costs and improve care by preventing chronic diseases and getting better treatment to people who have them. Vermont's majority-Democrat legislature endorsed and funded the Republican Governor's Blueprint in 2006, and created a new public-private insurance expansion called Catamount Health. In a remarkable burst of reform activity from 2006 to

2008, the legislature approved and the Governor signed 11 health reform bills with over 60 specific initiatives to increase access, improve quality, and contain the cost of health care in Vermont.³

Setting the Stage for High Performance

Vermont has a long history of political debate on the tension between health coverage and cost control. A major health reform effort in 1994 failed in part because of the inability of political leaders to reconcile the goal of covering the uninsured and the goal of containing costs for the insured.⁴ A decade later, the debate again focused largely on how to finance coverage for the uninsured. In 2005, the General Assembly proposed a new payroll tax to support universal coverage, but some residents who already had health insurance (90 percent of the population was insured at the time) were convinced that they would pay even more for health care and receive less, and Gov. Douglas ultimately vetoed the bill.⁵

Although universal coverage did not pass in 2005, legislation was enacted to fund a new legislative Commission on Health Care Reform. The Commission was cochaired by Senate health chair Jim Leddy and his counterpart in the House, John Tracy. Both Democrats, Sen. Leddy and Rep. Tracy held hearings throughout the state, authored principles for reform with the Vermont Business Roundtable, and developed a new reform bill, which the Governor signed in January 2006. The final legislation struck a balance between controlling costs and expanding coverage. It funded the Governor's Blueprint priorities to modernize how care is delivered and create a statewide health information technology system—and it created a new public-private health plan called Catamount Health to cover uninsured Vermonters.

Coverage

Census data used in the State Scorecard indicate that 86.5 percent of Vermont's nonelderly adults had health insurance in 2007–08 and 93.4 percent of children were insured. However, according to the Vermont Household Health Insurance Survey, since 2005 insurance rates for Vermont children have increased dramatically (2.0 percentage points) to 97.1 percent in 2008.⁶

Since 1997, the Vermont Department of Banking, Insurance, Securities, and Health Care Administration (BISHCA) has conducted periodic household health insurance surveys to monitor the health insurance coverage status of Vermont residents and related demographic, employment, and economic characteristics. Vermont's state-sponsored surveys include a more robust sampling approach than the federal Census Bureau's Current Population Survey and are tailored to specifically address health insurance issues. Early surveys supported efforts to target Medicaid outreach, and data from the 2005 survey provided data on the uninsured that was used to develop health care coverage reforms enacted in 2006. Three years into reform, the state reports 13,771 fewer Vermonters are uninsured, about 23

percent of the previously uninsured population (Table 4). More than half of the gain in insurance coverage since 2005 was achieved through the Medicaid program. There were also significant gains in military health insurance coverage and a modest gain in private coverage.⁷

Medicaid, Dr. Dynasaur, and the Vermont Health Access Plan

Vermont has significant experience using Medicaid waiver authority to expand coverage for the uninsured. The state was working to enact universal health insurance coverage early in the 1990s and, although the broader effort achieved less than universal coverage, Medicaid was expanded in an effort to cover most children. Today, the Dr. Dynasaur program provides Medicaid coverage to all children with household income under 300 percent of the federal poverty level, to pregnant women under 200 percent of poverty, and to parents and caretakers under 185 percent of poverty.⁸ The Vermont Health Access Plan (VHAP) provides coverage for adults who have been uninsured for at least 12 months and are not otherwise eligible for Medicaid or Dr. Dynasaur, up to

Table 3. State Scorecard on Health System Performance: Vermont

	Overall and Dimension Rankings		Number of 2009 Indicators in:		Number of Indicators That Improved by 5% or More
	Revised 2007 Scorecard	2009 Scorecard	Top Quartile of States	Top 5 States	
OVERALL	2	1	22	8	14
Access	12	13	1	0	0
Prevention & Treatment	6	3	10	3	9
Avoidable Hospital Use & Costs of Care	9	11	7	3	1
Equity	2	2	*	*	*
Healthy Lives	10	8	4	2	4

Note: Data were available to rank Vermont on all 38 State Scorecard indicators in 2009. Trend data were available for 35 indicators.

* The equity dimension was ranked based on gaps between the most vulnerable group and the U.S. national average for selected indicators; thus, it is not included in indicator counts.

Source: The Commonwealth Fund, Oct. 2009.

150 percent of poverty. The 2006 health reform expanded Medicaid benefits to include a new Chronic Care Management Program (CCMP) and to create new Medicaid reimbursement incentives to improve care for people with chronic conditions.

Employer Sponsored Insurance Premium Assistance

Adults currently enrolled in the Medicaid VHAP program and new VHAP applicants who have adequate access to employer-sponsored insurance (ESI) are required to enroll in their ESI plan, if it meets state minimum requirements. The state provides subsidies to ensure that the individual’s out-of-pocket obligations are no more than premiums and cost-sharing under VHAP. The state also offers supplemental benefits or “wraparound” coverage to ensure VHAP-eligible enrollees continue to receive the full scope of benefits available under VHAP.

The ESI Premium Assistance Program also makes health coverage more affordable for uninsured low-income residents who are not eligible for Medicaid or VHAP. For uninsured people with incomes under 300 percent of poverty who have access to ESI coverage, the state provides a subsidy of premiums or cost-sharing amounts based on the household income of

the eligible individual. However, if providing the individual with assistance to purchase Catamount Health is more cost-effective to the state than providing the individual with premium assistance to purchase the individual’s ESI plan, then the state enrolls the individual in the Catamount Health Assistance Program.

Catamount Health

Catamount Health is a public–private health insurance program that offers a lower-cost comprehensive health insurance product to uninsured residents.⁹ Catamount Health is modeled after a preferred provider organization plan with a \$250 in-network deductible and \$800 out-of-pocket maximum for individual coverage. Plans are required to include coverage and waive cost-sharing for chronic care management programs and preventive care, including immunizations, screening, counseling, treatment, and medication. Mental health coverage is subject to the state’s mental health parity law, which has been in place since 1997 and continues to be one of the most progressive in the country. Catamount Health provider rates are established in law and are lower than commercial rates but 10 percent higher than

Table 4. Vermont’s Insured Population Since the Implementation of Health Reform

Type of Insurance	2005	2008	Change 2005–2008	Percent Change 2005–2008
Private*	369,348	371,870	+2,522	+0.7%
Medicaid	91,126	99,159	+8,033	+8.8%
Medicare	90,110	88,027	–2,083	–2.3%
Military	9,754	14,910	+5,156	+52.9%
Uninsured	61,057	47,286	–13,771	–22.6%
Total Members	621,395	621,252	–143	+ 0.0%
Est. Percentage Insured	90.2%	92.4%		

* Private health insurance coverage includes 9,326 covered through Catamount Health as of November 2008.
Source: Vermont BISHCA, “2008 Household Insurance Survey: Refresher and Updates,” July 2009.

Medicare rates. Blue Cross Blue Shield of Vermont and MVP Health Care began offering Catamount Health policies in October 2007.

Catamount Health includes a premium assistance program. The state pays the difference between an individual's specified contribution—ranging from \$60 per month for residents with income up to 175 percent of poverty to the full cost of the Catamount Health policy for those over 300 percent of poverty—and the premium for the lowest-cost Catamount Health Plan, which was \$393 per month as of August 2009. Any additional premium amount incurred because an individual chooses to enroll in a higher-cost Catamount Health plan is paid by the individual. Approximately 73 percent of Catamount Health enrollment consists of previously insured residents who switched to a Catamount plan, and 27 percent are residents who were previously uninsured.

Vermont is one of only a few states that requires guaranteed issue and community rating.¹⁰ The state does not currently have an individual mandate to purchase insurance, but the 2006 health reform requires that if less than 96 percent of Vermont's population is insured by 2010, then the legislature must "determine the needed analysis and criteria for implementing a health insurance requirement by January 1, 2011." Also, 2008 reforms require that the Commission on Health Reform study the feasibility of merging the nongroup (including Catamount), small group, and association health insurance markets by 2011.

Prevention and Treatment

Vermont ranks very high—third among all states—in terms of the quality of preventive care and treatment. The state improved its performance on most State Scorecard quality indicators from 2007 to 2009, with substantial gains on several key measures, including the

rates of adults (age 50 and older) receiving appropriate screening and preventive care (which increased nearly 5 percentage points, representing an 11 percent relative improvement from baseline), and of diabetic patients getting recommended services to prevent disease complications (which increased nearly 10 percentage points, for a 22 percent relative improvement).

Vermont is investing significant public funds to redesign the state's health system to improve quality and cost-effectiveness by preventing chronic diseases and getting better treatment to people who have them. Seventy percent of Vermont's health care costs can be attributed to care for a chronic condition.¹¹ This urgent fact led the Governor to initiate and the legislature ultimately to fund Vermont's Blueprint for Health.

Blueprint for Health

Vermont's Blueprint for Health is a public-private plan to create a statewide system of care to improve the lives of individuals with, and at risk for, chronic conditions. It is designed to provide patients with the knowledge, skills, and supports needed to manage their own care and make healthier choices; give providers the training, tools, and financial incentives to ensure treatment consistent with evidence-based standards of care; support communities to address physical activity, nutrition, and other behaviors to prevent or control chronic diseases; assist providers to have information technology tools to support individual care and population-based care management; and develop common performance measures and clinical guidelines for chronic conditions, improve systems coordination, and link financing mechanisms and insurance reimbursement with the attainment of chronic care treatment goals.

Blueprint activities are designed to meet the specific needs of individual communities, and can be

scaled to fit the population and intensity of need. “Even in a small state like Vermont, the real action is at the community level,” says Jim Hester, Ph.D., director of the legislative Health Care Reform Commission. “That’s where the pieces of health reform come together.” Every community in Vermont has implemented at least one component of the Blueprint, and full implementation is set for January 2011.

The Blueprint initially focused on chronic care management for people with diabetes in six of Vermont’s 13 hospital districts.¹² These projects started to change how health care providers and policymakers thought about *systems* of care, and illustrated the power of *integrated* systems of care. The state leveraged the lessons learned in these early sites into broader reform, and created pilot programs in three counties to test new ways of paying for care to help practices establish integrated systems. These pilots require commercial insurers, Vermont Medicaid, and Medicare (with Blueprint subsidies) to provide 1) enhanced reimbursement on top of negotiated rates to providers that meet certain medical home standards, and 2) direct financial support for local multidisciplinary Community Care Teams to support system integration and planning. Each Community Care Team includes clinical staff who are selected for the team based on specific community needs, and a public health prevention specialist who is based in the local health department district office. The Community Care Team provides support and expertise to participating medical practices through direct services and care coordination, population management, and quality improvement activities.

“Payment reform is the key to system change,” says Craig Jones, M.D., director of Blueprint for

Health. “We have to make quality primary care economically attractive,” he says, “and provide the basic infrastructure—Community Care Teams in Vermont—to address risk factors across a community.”

Statewide Health Information Technology

Vermont’s health care reform also includes a plan to improve Vermont’s health information technology (HIT), which mirrors the Community Care Team model in its effort to bridge public health and health care delivery. The state established a Health Technology Fund in 2008, financed through an assessment of 0.199 percent of all health insurance claims, to support the development of a health information exchange with Vermont Information Technology Leaders (VITL), the state’s private, non-profit Regional Health Information Organization. VITL operates the exchange, provides grants to assist practices in adopting electronic health records (EHRs), and offers clinical transformation consultation to help providers adopt and use electronic health information technology.

In 2008, Vermont selected DocSite to provide a Web-based clinical tracking system, populated with health information from the VITL exchange. The DocSite tracking system is a critical component of the Blueprint pilots. It has many but not all of the features of an EHR, and gives health care providers free access to treatment guidance at the point of care, electronic prescribing and a flexible reporting tool that supports population management. VITL intends DocSite to serve as a bridge to help providers transition from a paper-based practice and prepare to use a complete EHR.

Potentially Avoidable Use of Hospitals and Costs of Care

Vermont ranks in the top quartile of states on all but one of the State Scorecard's eight indicators of potentially avoidable hospital use, and in the top five states on three of these indicators. Costs present a mixed picture: Vermont is among the most expensive states for employer-sponsored health insurance premiums, which were 12 percent higher than the national average for individuals in 2008. Conversely, Medicare spending per capita was 12 percent lower in Vermont than the national average in 2006.

The Blueprint for Health's focus on prevention and chronic care management is expected to reduce the overall demand for high-cost treatment services over time, and reduce the growth rate in health care costs throughout the system. In addition, the state has several programs that are specifically designed to improve health system efficiency. Since 2003, Vermont hospitals have been required to publish annual hospital community reports containing information about quality, hospital infection rates, patient safety, nurse staffing levels, financial health, cost for services, and other hospital characteristics. BISHCA publishes much of this information on its Web site.¹³ Also, all Vermont hospitals report medical errors to the state's Patient Safety Program, including a Root Cause Analysis and Action Plans following each reportable event. Although not in legislation, Gov. Douglas and the Vermont Association of Hospitals and Health Systems announced in January 2008 that all hospitals in Vermont will not seek payment from patients or insurers for hospital care resulting in eight rare but serious adverse events.¹⁴

The state also is pursuing administrative reforms to improve health system efficiency. All of Vermont's state-supported coverage programs—Medicaid, premium assistance programs, and Catamount Health

Plans—are currently marketed under an umbrella brand called “Green Mountain Health.” The Department of Children and Families is currently working to implement an eligibility modernization project across these programs to replace outdated systems (e.g., clients must still complete lengthy paper applications, and repeat the process at least annually when eligibility is reviewed). The state is also creating a new Vermont Healthcare Claims Uniform Reporting System (VHCURES), a multipayer database that contains claims data from all private and public insurance plans to help the state better understand the effectiveness and efficiency of the health care delivery system.

Since 2006, Vermont's health reform investments include Medicaid coverage expansions, some provider rate adjustments, premium assistance programs for employer sponsored insurance and Catamount Health Plans, and other Blueprint programs. The financing of Vermont's health reform is based on the principle that everybody is covered and everybody pays. Individuals pay sliding-scale premiums based on income. Employers pay a health care contribution based on the number of their employees (measured as full-time equivalents) who are uninsured (\$91.25 per uninsured FTE per quarter, or \$365 per year). Other revenues come from an 80-cent increase in the cigarette tax, Medicaid programs savings due to employer-sponsored insurance enrollment, and through matching federal dollars under a federal Medicaid 1115 demonstration waiver called Global Commitment to Health. The Medicaid waiver is particularly important to sustaining reform. It consolidated funding for most of the state's Medicaid programs and converted the Office of Vermont Health Access (the state's Medicaid agency) into a public managed care organization (MCO). Under the waiver, the MCO can invest in health services that

typically would not be covered by Medicaid, and has more flexibility to implement creative programs and payment mechanisms to curb health care costs.

Healthy Lives

Vermont has the third-lowest rate of mortality amenable to health care among the states, with a nearly 16 percent reduction over three years—from 81 deaths per 100,000 population in 2001–02 to 68 deaths per 100,000 in 2004–05. Adult smoking has also declined substantially. However, some measures, such as infant mortality and childhood obesity, are moving in the wrong direction.

From the beginning, Vermont approached health reform with an emphasis on public health. Public health and clinical medicine have common roots but over time have grown apart—the Blueprint is attempting to bring them back together. Clinical professionals and public health prevention specialists work together on the Blueprint’s Community Care Teams. The state’s health information exchange collects and shares information that is relevant for individuals at the point of care and that is used to track risk factors across populations. Catamount Health includes coverage and waives cost-sharing for chronic care management and preventive care, and Medicaid includes new benefits and reimbursement incentives to improve chronic care management.

The Blueprint also has reinvigorated traditional public health activities. The state sponsors Healthier

Living Workshops that target people with arthritis, asthma, heart disease, chronic pain, and other chronic conditions. The Fit & Healthy Vermonters Initiative focuses on preventing obesity by encouraging physical activity and healthier eating in schools, worksites, early childcare sites, and other settings. And the Department of Health is implementing a process to enable the provision of clinically recommended immunizations to all residents across the lifespan at no cost when not otherwise reimbursed.

Conclusion

Vermont persevered through several health reform setbacks until its political leadership was able to strike a sustainable balance between expanding coverage and controlling costs. Vermont’s approach is not simple—it involves nine reform bills and more than 60 initiatives, including payment reform, new models for delivering care, a statewide information technology system, and a new public–private health coverage program. But it is the comprehensiveness of the reform that many of Vermont’s policy leaders credit as its success. The complexity of health care and its many dysfunctions, they say, require multiple, integrated solutions to expand access, improve quality, and control costs. The *State Scorecard* indicates Vermont’s robust combination of strategies is working—the state continues to improve its already-high scorecard rankings—and is a useful model to inform other state efforts.

HAWAII: AN EARLY QUEST FOR COVERAGE

Hawaii has one of the healthiest populations in the nation, as measured by the Commonwealth Fund's *State Scorecard on Health System Performance, 2009* (Table 5). Compared with most states, fewer people in Hawaii smoke and are overweight or obese, and more people are engaged in regular physical activity, which is not a surprise given the state's natural beauty and diverse geography. However, Hawaii also has its share of health-related challenges. For example, Hawaii has the highest *incidence* of breast cancer of all 50 states, but it also has the lowest *death rates* for breast cancer. How is that possible? Hawaii's residents have excellent access to primary and preventive care, say the states health experts, and that reduces preventable mortality and enables early identification and management of chronic disease.

The 2009 *State Scorecard* backs up the claim that Hawaii outperforms most states in terms of access to care. For example, cost is less of a barrier to care in Hawaii than in any other state, and more adults have a regular source of care. Also, Hawaii has much higher rates of insurance coverage than other states, mainly because of a 1974 employer mandate to provide insurance for employees. Ironically, Hawaii is sometimes criticized because its employer-mandate does not achieve universal coverage and leaves some residents uninsured. But that mistakes the purpose of the mandate, say its authors, which is to guarantee access to health insurance for working families only. Otherwise, Hawaii is just like any other state that is working to bridge the gap between private insurance and the state's public programs.

Coverage and Costs

For three decades, Hawaii has outperformed most other states in access to health insurance for children and adults. (In 2007–08, 89.4 percent of nonelderly adults

and 94.9 percent of children had health insurance coverage in Hawaii, ranking the state second and fourth, respectively.) Hawaii has done both while maintaining the lowest-cost private insurance premiums in the nation and the lowest Medicare costs per beneficiary.

The cost of living in Hawaii is 30 percent to 40 percent higher than on the mainland for just about everything *except* health insurance. Hawaii is nearly tied with North Dakota for the lowest employer-sponsored health insurance premiums of any state (\$3,831 for individuals in 2008), about 13 percent below the national average.¹⁵ Medicare costs per beneficiary are 31 percent below the national average.

There are many possible explanations. For example, as mentioned above, Hawaii's population is generally healthier, and has good access to primary care, both of which are likely to translate into lower health insurance costs. Also, Kaiser Permanente, a high-performing integrated delivery system, has a significant presence in the state and has been a leader in using health information technology to improve the quality and efficiency of care.¹⁶ Kaiser's Hawaii region experienced a 26 percent decrease in the rate of physician visits following implementation of electronic health records.¹⁷

The Prepaid Health Care Act of 1974

For more than three decades (until Massachusetts in 2006), Hawaii was the only state in the nation with a law mandating that employers provide health insurance to their employees. The Prepaid Health Care Act of 1974 requires nearly all employers to provide health insurance to their employees who work 20 hours or more a week for four consecutive weeks. Employees must maintain the minimum of at least 20 hours a week to remain eligible. The employer may withhold 50 percent of the premium cost from employees, not to exceed 1.5 percent of their

monthly gross wages, and must pay the balance of the costs. Coverage for the prepaid health insurance plan must be equal to those provided by the plan with the largest number of subscribers in Hawaii. Some employers are exempted from the Act, including government services, approved seasonal employment, insurance agents and real estate salespersons paid solely by commission, and sole proprietors with no employees.

Hawaii's Prepaid Health Care Act passed the same year as the federal Employee Retirement Income Security Act of 1974 (ERISA), which superseded all state laws related to employee benefits. Under ERISA, states cannot require employers to offer health coverage or dictate the terms of health plan coverage—but this is exactly what Hawaii proposed to do in its Prepaid Health Care Act. The passage of ERISA set up a jurisdictional showdown between the State of Hawaii and the federal government that culminated when Standard Oil sued to invalidate Hawaii's employer mandate and won. Hawaii's congressional delegation stepped in and

secured an exemption from ERISA, but on the condition that no major changes be made to the Prepaid Health Care Act as it was passed in 1974. This history and the role of ERISA explains why for so long only Hawaii enacted an employer mandate, and why the recent mandate in Massachusetts was carefully and creatively constructed to avoid an ERISA challenge.

After the Prepaid Health Care Act became law, the uninsured rate in Hawaii dropped from 30 percent to 5 percent, but recently has risen to 10 percent. The legislative authors of the Act never claimed it would achieve universal coverage—it only guarantees access to health insurance for people who work 20 hours or more a week. For what it was intended to do, the Act has been a success, resulting in a much higher rate of employer-sponsored health insurance coverage in Hawaii (61.8 percent) compared with the nation overall (53.4 percent).¹⁸ For other residents who do not work or work less than 20 hours a week, the state has relied on other strategies to provide coverage, primarily through Medicaid expansions.

Table 5. State Scorecard on Health System Performance: Hawaii

	Overall and Dimension Rankings		Number of 2009 Indicators in:		Number of Indicators That Improved by 5% or More
	Revised 2007 Scorecard	2009 Scorecard	Top Quartile of States	Top 5 States	
OVERALL	1	2	22	14	15
Access	1	6	3	3	0
Prevention & Treatment	16	16	8	4	10
Avoidable Hospital Use & Costs of Care	5	5	6	4	1
Equity	6	10	*	*	*
Healthy Lives	1	2	5	3	4

Note: Data were available to rank Hawaii on 36 of 38 *State Scorecard* indicators in 2009. Trend data were available for 33 indicators.

* The equity dimension was ranked based on gaps between the most vulnerable group and the U.S. national average for selected indicators; thus, it is not included in indicator counts.

Source: The Commonwealth Fund, Oct. 2009.

Medicaid QUEST

Hawaii's QUEST program provides comprehensive Medicaid coverage across the state to children and adults through capitated managed care plans. The program was originally approved in 1994 as a Medicaid section 1115 demonstration waiver to expand coverage to individuals not otherwise eligible for Medicaid. Since 1994, the QUEST program has expanded to provide full Medicaid benefits to pregnant women with incomes up to 185 percent of the federal poverty level, children with incomes up to 300 percent of poverty, and qualified adults with incomes at or below 100 percent of poverty. The state also provides a more limited benefit package to QUEST-eligible adults if their income goes above 100 percent of poverty, up to 300 percent of poverty (QUEST-Net), and to childless adults up to 100 percent of poverty (QUEST-Adult Coverage Expansion).

In February 2008, Hawaii received federal approval to amend its 1115 waiver and expand the QUEST program to also cover aged, blind, and disabled (ABD) Medicaid beneficiaries. The new program, called QUEST Expanded Access (QExA), will transition the ABD population from fee-for-service into a managed care delivery system for all covered services, including primary, acute, home- and community-based services, and long-term care. The state

recently awarded contracts to two managed care organizations to begin implementing the program (the waiver requires the program to be fully implemented within five years). The waiver allows the state to count savings from ABD managed care to meet the budget neutrality requirements of the waiver, which means the state will be able to use those savings to cover more people through QUEST programs with financial support from the federal government.

Conclusion

In the decade before Hawaii enacted its employer mandate to provide health insurance for employees, there was much discussion at the national level on the provision of compulsory national health insurance. The concerns in the 1960s were much as they are now: legislators were faced with rising health care costs, limited access to health insurance and services for certain populations, and state and national economic concerns. Hawaii's legislature acknowledged this discussion, and included a clause in the Prepaid Health Care Act which would invalidate the Act if a form of national health insurance was developed and implemented. Today, 35 years later, the Prepaid Health Care Act remains in effect, and the national debate about how to expand coverage, improve quality, and control costs continues.

IOWA: WORKING HARD TO BENEFIT CHILDREN

Iowa residents are known for hard work and, when confronted with a challenge, working cooperatively to get done what needs to be done. The state has a rich history of collaboration through its agricultural extension service, and this way of thinking has also characterized the state's approach to health system performance, with a special emphasis on making sure the system is working well for children. Nearly all children in Iowa have access to health insurance coverage either through private insurance or Iowa Medicaid programs. The state's health care delivery system is characterized by a few well-organized systems of care that are oriented toward quality improvement, and the state is known as an innovator in Medicaid program performance. These activities are reflected in very high health system performance: Iowa is among the top quartile of states on more than half of *State Scorecard* indicators, and ranks second (with Hawaii) on overall health system performance (Table 6).

Coverage

Iowa ranks among the top six states in adult health insurance coverage and ranks second in the rate of coverage for children, which is particularly high, reaching 95 percent in 2007–08. According to the Iowa Child and Family Household Health Survey, the uninsured rate among children decreased from 6 percent in 2000 to 3 percent in 2005.

Iowa families view health insurance coverage as a priority and go out of their way to seek coverage. “It’s not unusual for a spouse to drive miles away from the family farm,” says Peter Damiano, director of the University of Iowa Public Policy Center, “just to work at a job that provides health insurance for their family.” As a result, Iowa’s uninsured rates are very low, and the portion of uninsured is more

highly correlated with low income—more than half of Iowa’s uninsured residents have family income below 200 percent of poverty. The Iowa ethic also gives a very high priority to supporting children, and the combination of these values has led to the creation of public programs that could achieve a 99-percent statewide health insurance coverage rate for kids, if every eligible child was enrolled.¹⁹

Medicaid and hawk-i

Iowa’s State Children’s Health Insurance Program covers children in families with income levels up to 133 percent of the federal poverty level through an expansion of Medicaid, and covers children between 133 and 200 percent of poverty through a private insurance program called Healthy and Well Kids in Iowa (*hawk-i*). Most uninsured children in Iowa (75 percent) are estimated to be eligible for Medicaid or *hawk-i*, but not enrolled. Recently, the state has increased its efforts to reach out to these children and get them enrolled. Iowa Medicaid contracts with private health plans to provide covered services to children enrolled in *hawk-i*, with little or no cost-sharing for families (no family pays more than \$40 per month). Iowa Medicaid also recently increased access to home- and community-based mental health services for seriously emotionally disabled children, up to 250 percent of poverty.

IowaCare

The IowaCare program was created in 2005 to cover a limited set of health care services for adults with income up to 200 percent of the federal poverty level. IowaCare benefits are provided through two government-run hospital systems (University of Iowa and Broadlawns Medical Center). This service delivery structure is reminiscent of (and replaced) an earlier “State Papers Program” that dated back to the

1920s and provided government certificates for uninsured residents to receive services in public hospitals. Today, the program is financed through a Medicaid 1115 demonstration waiver that allows the state to count \$35 million in money that the two government hospitals spend on services for Medicaid beneficiaries as state matching funds, to which the state adds \$65 million, and then draws \$175 million from the federal government. In total, the waiver provides \$275 million annually in spending authority for IowaCare.

IowaCare enrollees with family incomes above 100 percent through 200 percent of poverty are required to pay monthly premiums not to exceed 5 percent of family income. The program has intentionally and successfully enrolled a population with a high proportion of chronic illnesses, and provides coverage to a group that was previously uninsured for an extended period of time.²⁰ Average monthly enrollment is about 30,000, and a total of 60,000 Iowa residents have benefitted from IowaCare since its inception, far exceeding original enrollment estimates for the program.

Quality and Cost

Iowa's performance on prevention and treatment quality improved by 5 percent or more since baseline for two-thirds of the State Scorecard's indicators, and overall the state outperformed all but five states on this dimension in 2009. Private sector health insurance premiums for employed individuals in Iowa were 5 percent lower than average premium costs nationally in 2008, and Medicare costs per beneficiary were 21 percent lower than the national average as of 2006.

Iowa's health care delivery system is characterized by a few well-organized systems of care. Most of the state's physicians and hospitals are affiliated through two large, vertically integrated hospital systems (Iowa Health Systems and the Mercy Health Network). The University of Iowa Hospital supports both systems, and is the state's primary partner in serving Medicaid beneficiaries. These providers are leading the state's quality improvement efforts, working together through the Iowa Healthcare Collaborative.

Iowa Healthcare Collaborative

The Iowa Healthcare Collaborative (IHC) was created in 2004 through a partnership between the Iowa

Table 6. State Scorecard on Health System Performance: Iowa

	Overall and Dimension Rankings		Number of 2009 Indicators in:		Number of Indicators That Improved by 5% or More
	Revised 2007 Scorecard	2009 Scorecard	Top Quartile of States	Top 5 States	
OVERALL	3	2	21	11	14
Access	4	4	3	2	0
Prevention & Treatment	5	6	10	6	9
Avoidable Hospital Use & Costs of Care	12	14	4	2	1
Equity	15	8	*	*	*
Healthy Lives	8	7	4	1	4

Note: Data were available to rank Iowa on all 38 *State Scorecard* indicators in 2009. Trend data were available for 35 indicators.

* The equity dimension was ranked based on gaps between the most vulnerable group and the U.S. national average for selected indicators; thus, it is not included in indicator counts.

Source: The Commonwealth Fund, Oct. 2009.

Hospital Association and the Iowa Medical Society to improve the quality, patient safety, and value of health care in Iowa. IHC brings together physicians, hospitals, insurers, employers, government officials, consumers, and other community partners to explore new ways to improve quality and reduce cost. IHC collects and publicly reports comparative health care performance data, and translates that information into evidence-based measures and best practices for physicians and hospitals, ideas for insurers to pursue performance improvement, and assistance for employers to educate employees about wellness and prevention. IHC organizes all of these activities to complement other national quality and patient safety initiatives, and works closely with national organizations like the Institute for Healthcare Improvement, the National Patient Safety Foundation, federal agencies, hospital and medical associations, and others.

As new ideas about best practices emerge, IHC provides a ready-made forum to explore their application in Iowa. Current projects include: translating lessons learned from the IHC's Medical Home Learning Community, an initiative to make population-based care a core competency of all Iowa physicians, into standards for patient-centered medical homes; protecting patients by curbing health care-related infections; assisting hospitals to establish Medical Emergency Rapid Response Teams to bring critical care to the patient bedside at the first sign of decline (108 of 117 Iowa hospitals are participating); issuing simple "MedCard" information sheets about medications to improve communication between patients and health care providers; hosting Learning Communities to increase health system efficiency based on "Lean" techniques originally developed by Toyota; and serving as the Iowa field office for the national 5 Million Lives Campaign (5M) to reduce incidents of medical harm in all 117 Iowa hospitals.

Wellmark

In addition to provider-driven quality efforts, Iowa's largest insurance company, Wellmark Blue Cross and Blue Shield, has also been influential in moving quality indicators. Wellmark supports a medical home demonstration project to promote patient-physician collaboration and care coordination, and provides financial rewards for physicians who provide excellent diabetes care and share performance data with members, employers, and other clinicians. Wellmark also sponsors "Collaborating for Innovative Care," a series of Learning Collaboratives and personalized resources to help primary care practices establish care teams to improve the quality of diabetes care through process improvement and disease management techniques. The Learning Collaborative stresses teamwork, electronic data, and evidence-based guidelines as ways to improve provider performance.

Iowa Medicaid Enterprise

Iowa Medicaid is also a quality innovator, and has taken a one-of-a-kind approach in the organization of its Medicaid program to improve health system performance and efficiency. In 2005, the state split up its fiscal agent contract into nine separate functions, and competitively bid each function to find "best of breed" solutions. The resulting Iowa Medicaid Enterprise (IME) brings government staff and contracted experts together in one building to administer Medicaid. The emphasis of the program has shifted from paying claims to managing health system performance. The IME is extremely efficient, operating with 350 employees, only 80 of whom are state staff. IME team members work side-by-side and share a single, automated operating system to accomplish the state's goals for its Medicaid program. "The IME's internal collaborative approach has had a spill-over effect," says Tom Kline, D.O., medical director

for the Iowa Medicaid Enterprise. “Once our team experienced the power of collaboration,” he says, “it became the standard approach to solving all our problems, within Medicaid and beyond.”

Iowa also attempts to bridge private and public health to better address the varied needs of its children, exemplified in its 1st Five Healthy Mental Development Initiative, administered through the Department of Public Health. Participating pediatric offices are trained in mental health screening, and make referrals to specially trained public health care coordinators who further assess family needs, make appropriate referrals and follow-up, and inform the medical practices of the child’s status.²¹ This approach may contribute to Iowa’s high performance on the *State Scorecard’s* indicator of children who received needed mental health care, on which it ranks fifth among states with a rate of 75 percent.

Conclusion

Iowa’s commitment to health insurance coverage and quality improvement, particularly on behalf of children, is having a positive effect on the health of its population. Iowa improved on all but one of the

State Scorecard indicators related to healthy lives from the 2007 to the 2009 scorecards, including a dramatic 15 percent reduction in mortality amenable to health care from 2001–02 to 2004–05. Iowa is on solid ground when it comes to quality. But not satisfied, the state’s policymakers are planting new ideas to further improve quality and control costs. In 2007, a Legislative Commission on Affordable Health Care Plans for Small Businesses and Families conducted a comprehensive public discussion of health system reform. This discussion relied on local input and culminated in the enactment of comprehensive health care reform legislation in April 2008 (House File 2539). The reform bill created 11 new commissions to advance the recommendations of the original Commission, including working groups to implement patient-centered medical homes, establish strategies to prevent and manage chronic disease, adopt health information technology, and further expand coverage for children. These commissions are working now, and what they recommend will likely determine the contours of Iowa health policy in the future.

MINNESOTA: LAND OF 10,000 COLLABORATIONS

Minnesota has the nation's healthiest population, according to the *State Scorecard*, and a historically strong and inclusive health insurance system, both through employers and public programs. The health care marketplace in Minnesota is characterized by its nonprofit health plans and physician-led, integrated group practices, both of which seem naturally oriented toward collaboration. Over the past two decades, numerous coalitions have emerged to improve health system performance: government took the lead in the early 1990s to expand coverage, employers focused on value-purchasing, providers refined well-organized systems of care, and health plans developed community measures of health system performance. These efforts have contributed to very high health system performance. Minnesota outperforms most states on 2009 *State Scorecard* measures related to access, prevention and treatment, and healthy lives (Table 7).

Setting the Stage for High Performance

Minnesota's modern health reform efforts began in 1992, with an emphasis on coverage. The stage had been set for reform when Gov. Arne Carlson (Independent-Republican) vetoed a more extensive health care reform bill a year earlier but, in his veto message, signaled that he was willing to work with the legislature on a more targeted plan. State Senator Linda Berglin (Democrat-Farmer-Labor) and others in the legislature worked with the administration to develop the plan that became MinnesotaCare, a subsidized health insurance program for low- and moderate-income Minnesota residents who are unable to access affordable insurance on their own.

Since 1992, different sectors have emerged at different times to provide leadership for health system change. There has not been a formal structure in

place for health system reform, but rather informal and organic "coalitions of coalitions" that emerge, and work, and disband as the situation requires. The glue that holds the coalitions together, as some describe the process, is the progressive and neighborly outlook of the Upper Midwest. Occasionally, coalition activities reach a critical mass and need to be organized into structured reform, as they were in 1992. The most recent Minnesota health reforms, which were signed into law by Gov. Tim Pawlenty (R) in May 2008, invest in public health, modernize health system infrastructure, and propose new provider payment incentives to improve health care value.²²

Coverage

Minnesota ranks very high (third) among states in the percent of insured nonelderly adults; only Massachusetts and Hawaii have higher rates of adult coverage. And it continues to rank among the top quartile of states for children's coverage. Minnesota also scores very high on other access measures, including adults receiving routine checkups and cost not being a barrier to care.

Minnesota has a historically strong and inclusive health insurance system. The state's rate of coverage through private insurance is very high (67.5 percent) and publicly funded programs cover another one-quarter (25.2 percent) of the population, resulting in one of the lowest uninsured rates in the nation (7.4 percent).²³ Minnesota's public officials have provided consistent leadership over the past two decades to expand and sustain coverage options through three publicly funded health insurance programs: 1) Medicaid Medical Assistance (MA), 2) state-funded General Assistance Medical Care (GAMC) for low-income individuals (primarily adult men) not eligible for Medicaid, and 3) MinnesotaCare. "These programs are critically important to close the coverage gap between Medicaid and private insurance," says

Cal Ludeman, commissioner of the Minnesota Department of Human Services, “but we never lose sight that Medicaid is the public program that is doing the heavy lifting in terms of coverage.”

MinnesotaCare

MinnesotaCare is a state and federally subsidized health care program created in 1992 to provide health care to Minnesota children and adults who do not have health insurance coverage. The state made its financial commitment to the MinnesotaCare expansion *before* it was certain of federal support, by enacting a significant provider tax. Today, MinnesotaCare covers children and parents, legal guardians, foster parents, or relative caretakers up to 275 percent of the federal poverty level (Medicaid covers most children up to 170 percent of poverty and parents and caretakers up to 100 percent), and single adults and households without children up to 250 percent of poverty, some of whom are enrolled in MinnesotaCare through the GMAC program. As of April 2008, 115,000 residents (2.4 percent of Minnesota’s population) received health insurance through MinnesotaCare.

MinnesotaCare enrollees are covered by several different benefit sets and all receive services through managed care. Pregnant women and children have access to the broadest range of services and are not required to pay copayments. Parents and adults without children are covered for most services, but are subject to benefit limitations and copayments. Premiums for children up to 150 percent of poverty are \$4 per child per month. Children above 150 percent of poverty and adults pay a premium based on family size and income (the average monthly premium is \$24).

Medical payments for MinnesotaCare totaled \$463 million in 2008, or about \$338 per enrollee per month.²⁴ The state covers 61 percent of MinnesotaCare program costs with revenue generated from various provider taxes on health maintenance organizations, hospitals, and other health care providers.²⁵ Enrollee premiums and cost-sharing cover 8 percent of program costs. The remaining 31 percent of costs are paid by the federal government through a Medicaid Section 1115 demonstration waiver, called Prepaid Medical Assistance Project Plus (PMAP+). Minnesota was one of the early states to

Table 7. State Scorecard on Health System Performance: Minnesota

	Overall and Dimension Rankings		Number of 2009 Indicators in:		Number of Indicators That Improved by 5% or More
	Revised 2007 Scorecard	2009 Scorecard	Top Quartile of States	Top 5 States	
OVERALL	9	4	25	11	15
Access	5	2	4	1	0
Prevention & Treatment	13	8	7	5	8
Avoidable Hospital Use & Costs of Care	10	12	6	1	3
Equity	27	17	*	*	*
Healthy Lives	5	1	8	4	4

Note: Data were available to rank Minnesota on all 38 *State Scorecard* indicators in 2009. Trend data were available for 35 indicators.

* The equity dimension was ranked based on gaps between the most vulnerable group and the U.S. national average for selected indicators; thus, it is not included in indicator counts.

Source: The Commonwealth Fund, Oct. 2009.

use an 1115 waiver to cover uninsured populations. The federal waiver, which is approved through June 2011, is a critical source of funding to sustain MinnesotaCare, worth \$144 million in federal contributions annually.

Prevention and Treatment

Minnesota has made recent gains in the quality of preventive care and treatment relative to other states, improving its State Scorecard rank to eighth in 2009 with substantial improvement on half of the indicators in this performance dimension.

Minnesota's employers were among the first in the nation to identify great variation in health plan and provider quality. In 1988, General Mills, 3M, and other large self-insured employers in the state created a Buyer's Health Care Action Group (BHCAG) to create balance in a health care market they perceived as primarily influenced by health plans and medical providers. BHCAG challenged the state's health plans and providers to publish quality results so that consumers and employers would have the information they needed to reward optimal health plan and provider performance.

Despite some initial tension, Minnesota's health plan and provider community embraced market transparency and enhanced information as a strategy to drive quality.²⁶ Several factors made this possible. For example, the majority of care in Minnesota is provided through well-organized, physician-led group medical practices, most of which are fully integrated or closely aligned with a nonprofit hospital. (Several of these integrated systems, such as the Mayo Clinic, have national reputations for high performance.²⁷) Strong physician leaders emerged in these practices to embrace evidence-based practice and quality reporting as the right thing to do for patients.²⁸ In addition, Minnesota's health plans are

required by law to be nonprofit, so they have remained local entities with leaders who are in touch with community objectives. In response to BHCAG's challenge to report quality, the physicians and health plans created the Institute for Clinical Systems Improvement and MN Community Measurement.

Institute for Clinical Systems Improvement

The Institute for Clinical Systems Improvement (ICSI) was established in 1993 by HealthPartners, Mayo Clinic, and Park Nicollet Health Services to improve patient care in Minnesota through innovations in evidence-based medicine. As an independent, nonprofit organization, ICSI develops evidence-based health care guidelines and helps its members implement best clinical practices for their patients. Most Minnesota physicians (85 percent) participate in ICSI through 57 group practices, all of the health plans are involved, and business representatives also are involved in the decision-making process. ICSI is currently focused on redesigning outpatient care and exploring new methods for improving the patient-centeredness and value of care. For example, ICSI is developing recommendations for health care homes in response to 2008 health reforms, bringing medical groups and health plans together to improve care in the primary care setting for patients with depression, and launching a high-tech diagnostic imaging project that is expected to save lives and \$50 million in health care costs annually.

MN Community Measurement

MN Community Measurement (MNCM) was created by Minnesota's health plans in 2004 to report statewide health care quality measures across medical groups. Using ICSI guidelines and data supplied by the health plans, MNCM measures, compares, and reports "HealthScores" for over 700 provider groups

and clinics across the state. MNM HealthScores is a community asset, used by medical groups and clinics to improve patient care, by employers and patients as information about the cost and quality of health care services, and by health plans for their pay-for-performance programs. As a result of 2008 health reforms, MNM is working with the Minnesota Department of Health to accelerate and expand existing quality measures and to establish a state system of pay-for-performance.

Other Quality Initiatives

ICSI and MNM put Minnesota ahead of most states in its capacity to understand what contributes to health care value and health system performance. These organizations also create a forum to discuss, test, and act on new ideas. Minnesota is famously active in national quality initiatives, including the Quality Alliance Steering Committee (QASC), Network for Regional Healthcare Improvement (NRHI), Aligning Forces for Quality (AF4Q), Bridges to Excellence, and The Leapfrog Group for Hospital Patient Safety. Also, the state has implemented a policy to not pay for certain medical mistakes, and follows pay-for-performance standards for diabetes, hospital stays, preventive care, and cardiac care. In 2008, the U.S. Department of Health and Human Services designated Minnesota a Chartered Value Exchange, a special federal distinction for strong commitment to improving quality and value in health care.

Potentially Avoidable Use of Hospitals and Costs of Care

Minnesota is among the top fifteen states on most measures related to hospital admissions and readmissions and the top state on avoiding admissions among long-stay nursing home residents. It was among the least-

costly states in terms of Medicare spending per beneficiary in 2006. Employer-sponsored health insurance premiums were near the national median rate for employed individuals in 2008.

The same coalitions described above that are working to improve quality also are focused on cost control. To them, quality and cost are two sides of the same health care coin, and the goal is to strike a balance that delivers the best possible value for health care purchasers and consumers. In addition, other groups have formed specifically to focus on value purchasing. The Smart Buy Alliance, for example, is a group of public and private health care purchasers in Minnesota working together to drive greater quality and value in the market. The state also plays a major role. “We sit alongside our private sector counterparts,” says Cal Ludeman, “first and foremost as a purchaser of health services.” The Department of Management and Budget purchases care for about 120,000 state employees and their families through the Minnesota Advantage health benefits plan, and is ahead of most health care purchasers in using value-driven purchasing mechanisms.²⁹ Recently, the various coalitions that focus on both quality and cost have turned their attention to achieving better value through payment reform.

Payment Reform

Minnesota was an early leader in using payment reform to achieve better health outcomes. In 1997, for example, the state implemented Minnesota Senior Health Options (MSHO), a special managed care program that blends funds from the Medicare and Medicaid programs to improve the delivery and coordination of all Medicare and Medicaid services received by seniors who are eligible for coverage under both programs. MSHO has simplified and increased access to a broad range of services for

dually eligible seniors, and resulted in significantly fewer hospital days and preventable hospitalizations compared with the traditional Medicare and Medicaid programs.³⁰

Minnesota's health policy leaders generally agree that health care payment reform is the next big step to further improvement in system performance. "The system will continue to reward quantity over quality," says Scott Leitz, M.P.H., Minnesota's Assistant Commissioner of Health, "until we fix the currently dysfunctional payment system." The current federal debate about "accountable care organizations" is in part inspired by Minnesota's well-organized group medical practices. In 2008, there were efforts to move from the current fee-for-service system to one in which providers were held accountable for the total cost of care. Ultimately, however, this approach was not approved and the state's 2008 reforms took a more modest—but still important—approach to payment reform.

Minnesota's 2008 health reform establishes a single comprehensive set of provider quality metrics, requires a statewide system of quality-based incentive payments to be used by public and private health care purchasers, creates payments for care coordination to support "health care homes," and sets up a process to define "baskets of care" to bundle services together in a way that creates incentives for health care providers to cooperate and innovate to improve health care quality and reduce cost.³¹ The 2008 reform also establishes a process to group providers based on their total cost of care and quality of care to develop a value index for providers that will be transparent to the public and health care purchasers. Minnesota's health experts believe Provider Peer Grouping, a common set of information about cost and quality, is an essential first step toward achieving additional payment reforms and is the powerful strat-

egy in the short term to improve health system performance and influence redesign.

Minnesota e-Health Initiative

Minnesota is the first state in the nation to require all health care providers and group purchasers to exchange common health care business transactions electronically starting in 2009. The new requirement, which is expected to reduce health care administrative costs by more than \$60 million a year, applies not only to the conventional list of health plans and providers, but also to auto insurers, chiropractors, dentists, pharmacists, workers compensation insurers, and others. In addition, the 2008 health reform requires all health care providers and payers to use an electronic prescribing system by 2011, and requires all providers to have "interoperable" electronic health records by 2015. Also, the Governor announced a goal that all Minnesota residents have the option of an online personal health portfolio by 2011, and that all state employees have this choice by the end of 2009.

Healthy Lives

Minnesota ranks among the top 12 states on all eight healthy lives indicators in the State Scorecard. It ranks first in mortality amenable to health care and has the lowest percentage of children who are overweight or obese. It also has made significant strides in reducing adult smoking and is one of the few states to experience improvement (reduction) in adults reporting activity limitations.

The Minnesota Department of Health has compiled detailed reports of public health data for Minnesota and each of the state's 87 counties since 1996, and uses that information to plan prevention and wellness initiatives. In 2004, Minnesota was allocated \$2.5 million annually through 2009 from the federal government's Steps to a HealthierUS program

to implement chronic disease prevention efforts in Minneapolis, St. Paul, Rochester, and Willmar. Minnesota's Steps to a HealthierMN program has focused on reducing the burden of diabetes, obesity, and asthma and encouraging physical activity, good nutrition, and tobacco cessation. In 2008, HealthierMN served as the model for a new Statewide Health Improvement Program.

Statewide Health Improvement Program

While all of Minnesota's 2008 health reforms strive to improve health outcomes, an integral part of the health reform law is its public health component, the Statewide Health Improvement Program (SHIP). SHIP is a community-based effort to help Minnesota residents live longer, better, healthier lives by reducing the burden of chronic disease. In July 2009, the Minnesota Department of Health awarded \$47 million over two years through SHIP to 52 community health boards and eight tribal governments across the state. Local grantees are required to create community action plans, assemble community leadership teams and partnerships, and implement interventions from a menu of proven choices to reduce the burden of obesity and tobacco use in four settings: schools, work sites, health care settings, and the community.

Conclusion

Minnesota's "coalitions of coalitions" in health care have resulted in hundreds (one state official said "thousands") of individual health care providers, business leaders, and state officials being "trained up" to wrestle with the complexities of health system change. There is not a dominant, central organization that determines health system performance or sets reform priorities. "It's all a bit messy," confides one state official. But consistently the right leaders emerge at the right time to meet specific health system challenges and, when new ideas arise, there are hundreds, perhaps thousands, of potential health policy leaders ready to step up, make sense of the issue and, working together, act to improve the system.

MASSACHUSETTS: SHARING RESPONSIBILITY TO ACHIEVE NEAR-UNIVERSAL ACCESS

Massachusetts has achieved the highest health insurance rates in the United States as a result of comprehensive health reform legislation in 2006. The reform law, known as Chapter 58, offers an array of approaches to reduce the number of uninsured in Massachusetts, including a Medicaid expansion (MassHealth), subsidized private insurance coverage (Commonwealth Care), a private insurance purchasing pool (Commonwealth Choice), and a new state entity to help residents find affordable, high-quality coverage (Health Connector). This hybrid approach reflects a basic philosophy of Massachusetts’ reform that success is a shared responsibility: consumers, government, employers, insurers, and providers all have new obligations and receive new benefits under reform.

Three years into reform, Massachusetts is achieving very high levels of health system performance. The percent uninsured is at historically low levels,

and there have been widespread improvements in access to health care for working adults. Those adults are more likely to have a usual source of care and to have had doctor visits, preventive care visits, and dental care visits under health reform than before. These gains reflect both increases in insurance coverage and improvements in the coverage that is available.³² In addition to access gains, Massachusetts also outperforms most other states on measures of prevention and treatment and healthy lives, but ranks lower in terms of potentially avoidable hospital use and cost. Overall, Massachusetts outperforms all but six states on the *State Scorecard* (Table 8), and this level of performance does not yet reflect the full effects of reform. (There is a time lag for data collection in nationwide surveys and data sources.) Many of the key features of the Massachusetts reform were new ideas only three years ago—the Connector, for example—but now are familiar to policymakers and under consideration in federal reform.

Table 8. State Scorecard on Health System Performance: Massachusetts

	Overall and Dimension Rankings		Number of 2009 Indicators in:		Number of Indicators That Improved by 5% or More
	Revised 2007 Scorecard	2009 Scorecard	Top Quartile of States	Top 5 States	
OVERALL	6	7	14	11	14
Access	2	1	4	4	1
Prevention & Treatment	3	5	7	4	8
Avoidable Hospital Use & Costs of Care	36	33	0	0	1
Equity	1	7	*	*	*
Healthy Lives	8	6	3	3	4

Note: Data were available to rank Massachusetts on 37 of 38 *State Scorecard* indicators in 2009. Trend data were available for 34 indicators.

* The equity dimension was ranked based on gaps between the most vulnerable group and the U.S. national average for selected indicators; thus, it is not included in indicator counts.

Source: The Commonwealth Fund, Oct. 2009.

Setting the Stage for High Performance

Massachusetts has a unique history when it comes to health system reform. Its residents have repeatedly been exposed to debate about universal coverage. Chapter 58 was a bold step forward in 2006, but within reach because of earlier reforms in 1985, 1988, 1991, 1996, and 1997.³³ Even prior to the 2006 coverage expansion, Massachusetts outperformed all but one state in covering children and all but eight states in covering adults on the 2007 *State Scorecard*. Health reform in Massachusetts has always been a process of “continuous policy improvement,” says John McDonough, a legislative leader during the 1985 reforms and leading advocate for reform in 2006. (Mr. McDonough was senior advisor on national health reform to the late Massachusetts’ Sen. Edward Kennedy.)

The core political values of the majority of Massachusetts residents resonate with universal coverage. Ninety-two percent of residents think that health care is a right.³⁴ Massachusetts has many more Democrats and Independents than Republicans, especially compared with the rest of the country, and there is generally greater support to provide health insurance for all uninsured people among Democrats (65 percent) and Independents (45 percent) compared with Republicans (28 percent).³⁵ Indeed, public opinion—and an initiative to put universal coverage on the November 2006 ballot—played a critical role in pressuring Massachusetts’ leaders to enact health reform legislation.

Supporters of the ballot initiative, under the leadership of John McDonough and others, kept up the pressure for reform through Affordable Care Today (ACT!!), a coalition of community and religious organizations, labor unions, doctors, hospitals, community health centers, public health advocates, and consumers. Individual organizations like Greater

Boston Interfaith and the Blue Cross Blue Shield Foundation of Massachusetts created an early focus on coverage. And political leaders like Governor Mitt Romney (R), Senate President Robert Travaglini (D), Speaker of the House Salvatore DiMasi (D), and U.S. Senator Edward Kennedy (D) worked together to get the state and federal authority required to implement reform. Gov. Romney, in particular, set the terms of reform by insisting on an individual mandate and negotiating the terms of the Medicaid waiver that allowed the state to share the cost of reform 50/50 with the federal government.

The final contours of Massachusetts’ coverage expansion reflected the history and influence of its health care industry, which is characterized by a few very large, nonprofit institutions. It is not unusual for these institutions to collaborate in Massachusetts, unlike public–private or insurer–provider skirmishes in other places that distract from system performance. Also, Massachusetts is geographically small and mostly urban—a city-state with one very large but well-defined health care marketplace—where policymakers know each other and are used to workable compromise. Finally, Massachusetts has the advantage of wealth—median household income is \$58,286, higher than in all but six states—which has created the economic capacity required for the state to achieve near-universal coverage.

Coverage

Massachusetts ranks first among states on the State Scorecard’s indicators of insured children and adults. As a result of 2006 comprehensive health reform legislation, the state reports 97.4 percent of its residents now have health insurance coverage.³⁶ In 2007, the first full year of reform, Massachusetts’ rates of residents deferring needed care because of financial barriers were one-half the national average.³⁷

Shared responsibility is the foundation of Massachusetts' coverage expansion. Adults are required to purchase health insurance, provided there is an affordable plan available. Employers with 11 or more employees must make a "fair and reasonable" contribution to employees' health insurance costs or pay a "fair share contribution" of \$295 per worker annually.³⁸ Employers also must establish Section 125 payroll deduction plans to facilitate pretax purchase of insurance for workers. Insurers cannot refuse to cover people and can vary their premium for the same coverage only to a limited extent (these requirements were in place prior to reform). And taxpayers subsidize coverage for the poor who lack access to other insurance programs.

Chapter 58 also created the first private insurance market in the nation where an individual can buy health insurance coverage on the same terms and at the same prices as a small business, resulting in better coverage, better benefits, and prices that are significantly lower for individuals previously in the individual market. The combined market is subject to long-standing insurance protections, including guaranteed issue and renewal, a medical underwriting prohibition, preexisting condition limitations, and modified community rating.

As a result of the mandates and market reforms described above, the number of Massachusetts residents with health insurance increased by 428,000, giving the state by far the lowest rate of uninsured residents in the nation (Table 9). Enrollment in private insurance (private group and individual purchase) has grown by 190,000 since 2006, accounting for 45 percent of the total growth in coverage. In addition to better take-up rates for employer-sponsored and individually purchased insurance, Chapter 58 also created new sources of coverage through a Medicaid expansion, a new program to subsidize pri-

vate insurance coverage, and a private insurance purchasing pool, described below.

MassHealth

Chapter 58 expanded eligibility and benefits in Massachusetts' Medicaid program, called MassHealth. It expanded children's eligibility from 200 percent to 300 percent of the federal poverty level. Optional benefits for adults that were cut during the 2002–2003 recession, including dental care, dentures, and eyeglasses, were restored. Chapter 58 also increased MassHealth payment rates to physicians and hospitals, up to \$90 million per year in fiscal years 2007–2009. A portion of hospital increases in 2008 and 2009 were contingent on providers meeting "pay-for-performance" (P4P) standards. The standards include measures to reduce health disparities, the first P4P system in the nation to do so.³⁹

MassHealth enrollment also increased among those previously eligible and not enrolled. The use of a single application form for all programs, outreach grants to community groups, restrictions on the availability of hospital charity care reimbursement, and the individual mandate to purchase health insurance all combined to increase Medicaid enrollment. Overall, MassHealth enrollment has grown 10 percent since 2006, to 781,000 enrollees as of December 31, 2008 (Table 9).

Commonwealth Care

Chapter 58 created a new Commonwealth Care Health Insurance Program to provide subsidized insurance to uninsured adults with household incomes up to 300 percent of poverty who are ineligible for MassHealth or any other coverage.⁴⁰ Eligible people with incomes below 150 percent of poverty are charged no premiums, no deductibles, and modest copayments. Those with incomes of 151 percent

to 300 percent of poverty pay income-based, sliding-scale premiums and copayments, and no deductibles. Commonwealth Care plans cover inpatient, outpatient, and preventive services; behavioral health; prescription drugs; and dental services for those below 100 percent of poverty. The average current total monthly cost of a Commonwealth Care plan is \$396.⁴¹ Annual premium growth averages under 5 percent and (as of July 2009) government spending per enrollee and what enrollees contribute toward premiums *decreased* while, at the same time, choice of health plans and access to new primary care physicians *increased*. Commonwealth Care covered 163,000 people as of December 31, 2008 (Table 9).

Commonwealth Choice

Chapter 58 also created unsubsidized plans for people who are ineligible for Commonwealth Care and who do not have access to employer-sponsored insurance. Commonwealth Choice plans are administered by state-licensed private insurers. All Commonwealth Choice plans must meet the Connector's (described below) "minimum creditable coverage" standards by providing "reasonably comprehensive" benefits, including inpatient, outpatient, mental health, preventive services, and drug coverage.⁴² The Connector sets four levels of benefits from which customers can choose. The principle variation among the four levels involves cost-sharing, which increases sharply as premiums decrease.

Commonwealth Choice enrollees pay from \$1,500 to over \$15,000 a year, depending on their age, family size, and plan preference. Premiums mirror Commonwealth Care up to 300 percent of poverty. Above that, the maximum amount individuals and families must pay for health insurance increases to 9 percent of income at 500 percent of poverty, the median state income, at which point health

insurance is deemed affordable regardless of cost. Enrollees can shop for plans on the Connector's user-friendly Web site by entering just three pieces of information: the subscriber's age, household size, and zip code. Whichever plan the individual picks, enrollment is guaranteed, as is the next year's renewal, regardless of any change in the member's medical conditions.

The Connector

Chapter 58 assigned important implementation duties to a new state entity called the Commonwealth Health Insurance Connector Authority. The Connector sets standards for covered benefits in Commonwealth Care and Commonwealth Choice, evaluates the products before offering them, and organizes the choices of plans so members can easily compare them. It is governed by a 10-member board, including content experts, constituency representatives, and public officials. The legislature intentionally delegated some of the most contentious policy questions to the Connector, which sets the standard that satisfies the individual mandate (called "minimum creditable coverage"), decides what premium is considered affordable, and determines whether or not a person should be penalized under the individual mandate. Addressing these questions in statute might have jeopardized the legislative consensus and would have precluded the process of experimentation, feedback, and refinement that has marked the Connector's approach to policymaking. "It isn't often in politics, especially in Massachusetts, that the stars align so an achievement of the magnitude of the Connector Authority not only works, but works efficiently and fulfills a real social need," says Dolores Mitchell, executive director of the Massachusetts Group

Insurance Commission. “Kudos to all parties for a successful start,” she says.

Access to Providers

Adults in Massachusetts, although more likely to have health care visits under health reform than before, reported difficulty finding providers who would see them.⁴³ Internists accepting new patients and MassHealth patients dropped under health reform and wait times for appointments increased.⁴⁴ Some community health centers report longer waits for appointments after reform.⁴⁵

As coverage expanded, the demand for health services increased, particularly for primary care. Efforts are under way to enhance the supply of primary care practitioners and medical homes. One year after reform was enacted, private groups began to pilot incentives for recruiting and retaining young primary care clinicians, and the state approved retail clinics offering access to nurse practitioners in pharmacies. In 2008, the state authorized increased primary care training slots at the University of Massachusetts and special financial incentives for primary care clinicians. As a result, community health centers in Massachusetts have attracted 92 primary care clinicians to serve 100,000 newly insured people.⁴⁶

Also in 2008, the legislature set a goal to transform all primary care practices into patient-centered medical homes (PCMH) by 2015, and provided \$5 million to initiate a PCMH demonstration. That effort is being jump-started with an additional \$500,000 grant to participate in the Safety Net Medical Home Initiative, launched by The Commonwealth Fund, Qualis Health, and the MacColl Institute for Healthcare Innovation. Initially, 14 community health centers will be selected for PCMH implementation and, in parallel, the state will develop PCMH payment reforms to introduce in 50 to 100 high-volume Medicaid practices by January 2010. PCMH activities are the organizing framework for the state’s increasing focus to improve quality and control costs—the objectives that many believe will drive the next wave of comprehensive health reform.

Prevention and Treatment

Massachusetts ranks high among states in terms of the quality of preventive care and treatment. The state’s performance substantially improved on half of the State Scorecard indicators in this dimension from 2007 to 2009. On a few measures related to care received in hospitals and nursing homes, Massachusetts ranks in the middle compared with other states.

Table 9. Massachusetts’ Insured Population Since the Implementation of Health Care Reform

Type of Insurance	June 30, 2006	June 30, 2007	Dec. 31, 2008	Change since June 30, 2006	Percentage of Total Change
Private Group*	4,292,000	4,396,000	4,441,000	+149,000	35%
Individual Purchase*	40,000	36,000	81,000	+41,000	10%
Commonwealth Care	0	80,000	163,000	+163,000	38%
Medicaid/MassHealth	705,000	732,000	781,000	+76,000	18%
Total Members	5,037,000	5,244,000	5,469,000	+428,000	100%
Est. Percentage Insured	93.6%	94.3%	97.4%		

* Private group and individual purchase counts include 19,000 people enrolled in Commonwealth Choice plans.
Source: Massachusetts Division of Health Care Finance and Policy, May 2009.

Massachusetts' health care marketplace is characterized by nonprofit, mission-driven medical centers, and there are more academic medical centers per capita in Massachusetts than most states. These institutions take quality seriously, as reflected on the *State Scorecard*, but also are more expensive, which also is reflected. There are multiple organizations that for decades have been engaged in quality improvement, but there has not been a core set of priorities to guide a statewide quality agenda.

Chapter 58 established a new Quality and Cost Council to “develop and coordinate the implementation of health care quality improvement goals that are intended to lower or contain the growth in health care costs while improving the quality of care.” The Council, which is driven by Massachusetts' Division of Health Care Financing and Policy, has focused efforts on collecting hospital-specific information on cost and quality, and making that information available to the public. Also, the Massachusetts Department of Public Health is working with hospitals to develop effective approaches to prevent medical errors prior to enforcing a new law that will prohibit hospitals from billing for preventable events. “The hope is that when providers are not paid for medical errors,” says John Auerbach, Massachusetts' Commissioner of Public Health, “they will find ways to prevent them.”⁴⁷

Massachusetts is also one of nine states participating in a State Quality Improvement Institute (SQII) sponsored by AcademyHealth and The Commonwealth Fund.⁴⁸ Massachusetts' initiative builds on an ongoing project to reduce rehospitalizations (also sponsored by The Commonwealth Fund) and broadens the state's focus to coordinate multiple, simultaneous cost and quality reform efforts.

Potentially Avoidable Use of Hospitals and Costs of Care

Massachusetts ranks in the bottom half (33rd) among states in terms of potentially avoidable use of hospitals and costs of care. The state's Medicare 30-day readmission rate, for example, is 50 percent higher than the rate of the best-performing state. Employer-sponsored health insurance premiums are 10 percent higher for a single individual than the national median, and 25 percent higher than the best-performing state.

Massachusetts intentionally acted first to expand coverage, despite concerns about costs, reversing the typical argument that cost control is a prerequisite for expanding access. The result? “Only by controlling costs can Massachusetts sustain near-universal coverage,” says Jon Kingsdale, executive director of the Health Connector, “giving moral weight to the dry, abstract argument for cost containment.”⁴⁹ The strategy seems to be working; key government and health industry leaders are now engaged in devising a far-reaching cost-control agenda.

Massachusetts' Chapter 305 of the Acts of 2008 enacted some modest reforms aimed at cost, including support for automating medical records. It also created a Special Commission on the Health Care Payment System that in July 2009 recommended a complete overhaul of health care reimbursement. The Commission concluded that moving away from fee-for-service to a “global payment” is the best strategy to reduce growth in per capita health care costs and promote safe, timely, effective, equitable, and patient-centered care. The Commission envisions these payments being made to “accountable care organizations” composed of hospitals, physicians and/or other clinician and nonclinician providers working as a team to manage both the provision and coordination of care for the full range of services that patients are expected to need.⁵⁰

The Payment Commission’s recommendations are controversial, but that is not a surprise to the advocates of the 2006 coverage reforms. “The current fee-for-service health care payment system is a primary contributor to the problem of escalating costs and pervasive problems of uneven quality,” says Sarah Iselin, commissioner of the Massachusetts Division of Health Care Financing and Policy. “Through reform, Massachusetts is rethinking the link between how care is paid for and cost and quality, and how we can better motivate and reward effective, efficient, and patient-centered care,” she says.

Since 2006, Massachusetts’ health reform investments include MassHealth expansions and rate increases, Commonwealth Care subsidies, and payments to safety-net institutions. The Massachusetts Taxpayers Foundation estimates that health reform spending grew from a base of \$1.041 billion in 2006 to a projected \$1.748 billion in 2010 (Table 10). That is an increase of \$707 million, or about \$1,650 per newly insured person, half of which is supported by federal reimbursements. Federal funding is authorized under a Medicaid 1115 waiver, which was updated in December 2008 to allow growth in federal payments through June 2011—but only if the state spends additional federal funds on Commonwealth Care. Funding for the state share of

health reform comes from state general revenue funds, tobacco taxes, and assessments on insurers, hospitals, and employers.

Healthy Lives

Since 2007, Massachusetts substantially improved on half of the State Scorecard indicators related to healthy lives, including reductions in adult smoking and mortality amenable to health care. Childhood obesity, however, is moving in the wrong direction (as it is in the rest of the country), increasing slightly over the past decade: nearly one-third of Massachusetts’ children are now overweight or obese.

From the beginning of health reform, there was interest by some legislators and activists to ensure a strong connection between health insurance and public health. “As the coverage expansion was implemented and the focus on cost and quality intensified,” says John Auerbach, “the link to prevention and wellness was clear.”⁵² Nine state agencies are working together to align public health policies and practices, and are currently developing statewide action plans for preventing and managing diabetes, and for preventing and controlling chronic disease.

The 2006 reform also reinvigorated traditional public health activities. For example, Massachusetts raised tobacco taxes as a strategy to pay for higher-

Table 10. Massachusetts’ Health Care Reform Spending, Fiscal Years 2006–2010 (in millions)

Program	2006 Actual	2010 Projected	2006–2010 Change
Commonwealth Care	\$0	\$880	+\$880
MassHealth Coverage Expansions, Rate Increases, and Benefit Expansions	\$0	\$487	+\$487
Uncompensated Care Pool and Safety Net Trust Fund	\$656	\$381	–\$275
Supplemental Payments to Medicaid MCOs (federal)	\$385	\$0	–\$385
Total	\$1,041	\$1,748	+\$707

Source: Massachusetts Taxpayers Foundation; projections as of May 2009.⁵¹

than-expected enrollment in Commonwealth Care. The tax had an impact on the demand for tobacco products and boosted the number of calls received at the Department of Public Health's smoking cessation hotline. Another set of initiatives promotes diet and exercise. The state partnered with television and radio stations to implement a high-profile public information campaign on healthy eating, and to promote "Mass in Motion," a Web site offering information about staying healthy.⁵³ The state also now requires fast food restaurants to post calories on menus, and public schools to calculate students' body mass index and relay the information along with explanatory materials to their parents.

Conclusion

Chapter 58 offers abundant experience to inform other state efforts to summon stakeholders to a common purpose, expand subsidized coverage to lower-income uninsured people, find and enroll large numbers of eligible people, define meaningful measures of health insurance affordability for all income groups, enhance insurance access and affordability for individuals by merging the small-group and individual insurance markets, and create opportunities for consumers to compare competing insurance products on cost, benefits, and network restrictions.⁵⁴ Massachusetts' early success suggests sequencing reforms, providing adequate resources and flexibility for a long implementation, and eventually forcing a confrontation on costs.⁵⁵

WISCONSIN: BRIDGING THE GAP BETWEEN MEDICAID AND PRIVATE INSURANCE

Wisconsin was among the first states to separate Medicaid from welfare, and increase coverage for working families. Today, Wisconsin's publicly funded health care coverage programs look and function like private health insurance, and are driven by a moral imperative that Wisconsin residents not forgo care. The state has made significant gains on *State Scorecard* measures related to access and healthy lives (Table 11). These gains were achieved, say Wisconsin health experts, through a long history and culture of collaboration among key actors in health care. A significant proportion of the physicians in Wisconsin belong to large, well-organized group practices that are aligned or integrated with a tertiary-level hospital. These health organizations and systems have made transparency and data reporting a priority and, with support from Wisconsin's employers and health plans, have achieved consistently high national rankings for quality.⁵⁶ The state participates alongside the private sector in quality initiatives and keeps everyone focused on access and coverage. In February

2008, Wisconsin launched additional health reforms to provide universal coverage for children, simplify existing programs, and remove other barriers to stable coverage for families.

Coverage

Wisconsin ranks fourth among states in the percent of insured nonelderly adults and among the top quartile of states in coverage for children. Wisconsin's overall access ranking (ninth) is pulled down somewhat by a low percentage of at-risk adults who visited a doctor for a routine checkup, but the state has recently achieved substantial improvement on this measure, in contrast to the national trend which went in the opposite direction.

Wisconsin was an early leader in welfare reform, with numerous initiatives between 1987 and 1997 to strengthen families by promoting self-sufficiency and independence through work. As a safeguard against families losing access to health coverage as they moved from welfare to work, the state created a health coverage program called BadgerCare in 1997 to bridge the gap between Medicaid and private insurance. BadgerCare extended Medicaid benefits to

Table 11. State Scorecard on Health System Performance: Wisconsin

	Overall and Dimension Rankings		Number of 2009 Indicators in:		Number of Indicators That Improved by 5% or More
	Revised 2007 Scorecard	2009 Scorecard	Top Quartile of States	Top 5 States	
OVERALL	11	10	15	5	14
Access	13	9	3	2	0
Prevention & Treatment	9	13	6	2	8
Avoidable Hospital Use & Costs of Care	14	16	3	0	1
Equity	13	18	*	*	*
Healthy Lives	21	8	3	1	5

Note: Data were available to rank Wisconsin on all 38 *State Scorecard* indicators in 2009. Trend data were available for 35 indicators.

* The equity dimension was ranked based on gaps between the most vulnerable group and the U.S. national average for selected indicators; thus, it is not included in indicator counts.

Source: The Commonwealth Fund, Oct. 2009.

all children and adults in uninsured families with incomes below 185 percent of the federal poverty level and, once enrolled, allowed them to remain in BadgerCare until family income exceeded 200 percent of poverty.

The state expanded BadgerCare several times, most recently in 2008. The purpose of the program is no longer defined in relationship to welfare but, under Gov. Jim Doyle's (D) administration, connected to the idea that access to health care is a right that the state has a role in protecting. "We operate under a moral imperative that Wisconsin residents not forgo care," says Jason Helgerson, Wisconsin Medicaid Director. "We push ourselves to expand access, but also do our best to balance what beneficiaries and taxpayers want from our programs," he says. These values are at work in the 2008 expansion, called BadgerCare Plus.

BadgerCare Plus

BadgerCare Plus provides health insurance to Wisconsin residents through one comprehensive program that consolidates family Medicaid, the Children's Health Insurance Program (CHIP), and Healthy Start under one umbrella. BadgerCare Plus includes a standard plan that provides the same benefits as Medicaid's existing Medicaid program, and a new benchmark plan that is based on the benefit package provided by Wisconsin's largest low-cost commercial health plan.⁵⁷ The standard plan is available to families up to 200 percent of the federal poverty level, and those at higher incomes may participate in the benchmark plan. Children may participate in BadgerCare Plus at any income level, with those in families above 200 percent of poverty contributing to monthly premiums on a sliding scale. Parents and caretaker relatives with incomes up to 200 percent of poverty and pregnant women up to

300 percent of poverty also can enroll in BadgerCare Plus. There is also a new "core plan" that began enrolling childless adults with income up to 200 percent of poverty in June 2009. Nearly all BadgerCare Plus beneficiaries receive standard, benchmark, and core plan services through managed care.

Wisconsin markets BadgerCare Plus as an insurance program, not a public welfare benefit. The state emphasizes that all children can sign up for BadgerCare, which eliminates uncertainty about who qualifies. Adults and children sign up through the same program, so it is easier for the state to reach out to families and make sure everyone in the family has coverage. In addition to its own outreach activities and county-based offices, the state provides training and incentives for community organizations to identify and enroll eligible individuals (one program provided \$50 per new enrollment). The state also makes the application process as simple as possible, including an online tool called ACCESS, which screens eligibility for health care, food stamps, tax credits, and other benefits. ACCESS is popular among consumers: 82 percent of core plan applications have been submitted via the Web site.

As a result of the 2008 coverage expansion and aggressive outreach, the state has enrolled an additional 182,776 residents in BadgerCare Plus programs (Table 12). More than 100,000 children and 80,000 adults gained coverage as a result of the BadgerCare Plus expansion.⁵⁸

Wisconsin is financing the BadgerCare Plus coverage expansion with a variety of strategies, including premiums and cost-sharing for enrollees above 150 percent of poverty (above 200 percent for children), a hospital assessment that increases the federal funding available for Medicaid in the state, increased efficiencies in prescription drug purchasing, and a \$1 increase in the cigarette tax. The state covers 40

Table 12. Wisconsin’s BadgerCare Plus Enrollment

	Enrollment Before BadgerCare Plus	July 2009 Enrollment	Increased Enrollment
Standard Plan	483,919	639,617	155,698
Benchmark Plan	0	12,942	12,942
Core Plan	0	14,136	14,136
Total	483,919	666,695	182,776

Source: Wisconsin Department of Health Services, “BadgerCare Plus Statewide Enrollment” (Aug. 10, 2009).

percent of program costs and 60 percent is covered by the federal government. BadgerCare was so innovative when it was first created that it required a Medicaid 1115 waiver to operate, but now the programs for children and families mostly function under Wisconsin’s Medicaid State Plan, which means there is no federal cap on enrollment. A second 1115 waiver was approved in 2008 to cover childless adults and, because the waiver caps federal financial participation, the core plan is limited to 50,000 enrollees. The state covers its share of the 2008 expansion with a portion of its annual disproportionate share hospital (DSH) allotment.

BadgerCare Plus also expanded the state’s premium assistance program that pays an employee’s share of employer-sponsored health insurance. Premium assistance is available to Wisconsin residents at the same income eligibility levels that are used for BadgerCare Plus programs. In addition to subsidizing an employee’s monthly premium, coinsurance and deductibles, the premium assistance plan also pays for any BadgerCare Plus-covered services that are not included in the private insurance plan.

Quality, Healthy Lives, and Costs

Wisconsin’s performance improved modestly on most State Scorecard measures of quality from 2007 to 2009, but the state was among the most improved on healthy lives, with substantial reductions in mortality

amenable to health care, the percentage of adults who smoke and, counter to the national trend, the percentage of children who are overweight or obese. Although health insurance premiums for single employees in Wisconsin are more expensive than the national average, Medicare costs per beneficiary are lower than the average.

Wisconsin has a long history and rich tradition of collaborative relationships among key actors in health care, representing both providers and purchasers. The health care delivery system is characterized by a relatively large number of well-organized systems of care and large group practices. For example, approximately 50 percent of the state’s licensed physicians are in 18 medical groups, and most are completely integrated or closely aligned with a hospital.⁵⁹ Physician leaders like John Toussaint, M.D., president and CEO of ThedaCare Center for Healthcare Value, were early advocates for a systematic approach to improving patient safety and quality, and reducing costs.⁶⁰ They took the initiative to convene policy-makers to collaborate on quality measurement and improvement. In addition, the Wisconsin Hospital Association provided early leadership to make transparency and data reporting a priority. The business community was equally engaged, through business coalitions and individual employers. These groups and others leveraged their commitment to reform into multi-stakeholder initiatives like the Wisconsin

Collaborative for Healthcare Quality and the Wisconsin Health Information Organization.

Wisconsin Collaborative for Healthcare Quality

The Wisconsin Collaborative for Healthcare Quality (WCHQ) was established in 2003 by physician groups, hospitals, health plans, employers, and labor organizations that wanted to enhance transparency, promote improved quality, and reduce costs in Wisconsin's health care system. WCHQ publicly reports physician-level comparative information on its member physician practices, hospitals, and health plans through an interactive Web-based tool. Comparisons are organized into a range of conditions and quality dimensions such as diabetes management, hypertension, postpartum care, cancer screening, access to care, and patient experience. This approach is a model for other states.

"The Collaborative established significant credibility from the very beginning," says Chris Queram, president and CEO of WCHQ. "Its broad membership and technical expertise created a constructive tension around measurement that pushed everyone to improve system performance," he says. In addition to data collection and public reporting, the WCHQ provides a hub of activity for quality improvement, and brings multiple provider groups together in one place to focus on common objectives and develop strategies that embrace emerging best practices.

Wisconsin Health Information Organization

The Wisconsin Health Information Organization (WHIO) is another multi-stakeholder quality initiative, organized as a nonprofit collaboration of

managed care companies and insurers, employer groups, health plans, WCHQ, physician associations, hospitals, and state agencies. WHIO was established in 2005 to build a statewide, centralized multipayer health data repository based on voluntary reporting of private health insurance claims. The initial database includes health care claims as well as pharmacy and lab data from insurers and health plans; subsequent versions of the database will include additional health plans as well as Medicaid data. Beginning in early 2010, information in the database will be used to develop reports on the costs and quality of care in ambulatory settings. WHIO is funded with contributions by each member group, along with funds contributed by the state that are generated through a physician assessment.

Hospital CheckPoint and PricePoint

The Wisconsin Hospital Association (WHA) created the CheckPoint program to compare quality and error prevention measures among hospitals. The public information on the CheckPoint Web site (www.wicheckpoint.org) allows health care consumers and purchasers to see how virtually every hospital compares with others in the state and with national and state benchmarks on select measures of health care quality. CheckPoint reports data from 128 hospitals, covering 99 percent of admitted patients. The WHA also supports a Web-based program called PricePoint (www.wipricepoint.org) that allows consumers to compare costs at different hospitals. PricePoint shows the average discounts that hospitals allow for services under Medicare, Medicaid, and private insurance.

Conclusion

Health system performance in Wisconsin is driven by collaboration among providers with active participation across public and private sectors. Most physicians belong to large group practices that provide the infrastructure and technical assistance required to adopt evidence-based best practices, and hospitals have made transparency and data reporting a priority. These groups have aligned their quality-improvement activities through several multi-stakeholder organizations that place a very high priority on data

transparency and public reporting. “Our experience to date has shown that performance measurement is not a threat to Wisconsin’s providers,” says Chris Queram. “In fact, it is embraced as the foundation for quality improvement.” The state is an active participant in these activities, and additionally keeps everyone focused on access and coverage. Recent public health insurance reforms have made coverage virtually universal for children, and continue the state’s long tradition of working to bridge the gap between Medicaid coverage and private insurance.

DELAWARE: “THE DELAWARE WAY”

Delaware is an example of a state that improved on the most indicators of health system performance tracked by The Commonwealth Fund’s *State Scorecard*, particularly prevention and treatment measures (Table 13). Delaware outperforms most states on access-to-care measures but, unlike most states recently, has accomplished these gains by bolstering its safety net rather than expanding health insurance coverage. The state’s private health insurance market is strong, and Delaware Medicaid has income eligibility levels that are in line with other states (200 percent of the federal poverty level for children and 100 percent for childless adults).⁶¹ However, the state’s public and private health insurance programs leave about 12 percent of Delaware’s citizens without coverage, ranking Delaware in the middle among states in access to health *insurance*. Yet Delaware outperforms nearly every other state in access to and quality of health *care*, as measured by adults reporting no cost-related barriers to care and receiving routine checkups, older adults receiving recommended screening and preventive care, children receiving

mental health care when needed, and adults with a usual source of care.

“Universal health insurance coverage is our ultimate priority,” says Paula Roy, executive director of the Delaware Health Care Commission. “We have several coverage expansions ready to go, and have done a lot of work to prepare the way for universal coverage, but the economic downturn has forced us to focus on sustaining what we have, and what we have is a very strong safety net,” she says. The Commission-run Community Healthcare Access Program (CHAP) is specifically designed to link low-income, uninsured Delaware residents with low-cost or free care. Government officials, health care providers, health systems, and community organizations all join forces through CHAP to make sure residents “get covered and stay covered.” This very high level of collaboration is common in Delaware, say local policymakers, so common in fact it has a name: “The Delaware Way.” On a number of key health system performance measures, the Delaware Way appears to be working, and creating a firm foundation for future reforms.

Table 13. State Scorecard on Health System Performance: Delaware

	Overall and Dimension Rankings		Number of 2009 Indicators in:		Number of Indicators That Improved by 5% or More
	Revised 2007 Scorecard	2009 Scorecard	Top Quartile of States	Top 5 States	
OVERALL	19	14	13	8	17
Access	19	10	3	1	0
Prevention & Treatment	20	4	9	7	10
Avoidable Hospital Use & Costs of Care	35	38	0	0	2
Equity	9	4	*	*	*
Healthy Lives	32	34	1	0	5

Note: Data were available to rank Delaware on 37 of 38 *State Scorecard* indicators in 2009. Trend data were available for 34 indicators.

* The equity dimension was ranked based on gaps between the most vulnerable group and the U.S. national average for selected indicators; thus, it is not included in indicator counts.

Source: The Commonwealth Fund, Oct. 2009.

Access and Quality

Delaware ranks in the top quartile of states on adult coverage but performs in the middle among states in terms of health insurance coverage for children. It scores very high on most other access-to-care and related quality-of-care measures. For example, the state ranks second on the percent of at-risk adults who visited a doctor in the past two years for a routine checkup. And it is first in the nation for adults with a usual source of care and for residents over age 50 receiving recommended screening and preventive care.

Delaware is also one of the most-improved states in terms of access to preventive care and quality of treatment, jumping ahead of 16 states with dramatic improvements across most quality-related State Scorecard measures. Overall, it is one of only three states (plus the District of Columbia) that experienced relative improvement of 5 percent or more on at least half of the state's scorecard indicators with trends.

The Delaware Health Care Commission

In 1990, the Delaware General Assembly created a Health Care Commission to develop a pathway to basic, affordable health care for all Delaware residents. The 11-member public-private Commission allows creative thinking outside the usual confines of conducting day-to-day business. The Commission performs ongoing research and tracks the number and characteristics of the uninsured population in Delaware annually. It is responsible for exploring strategies to preserve and expand health insurance coverage, linking uninsured citizens with reliable health homes and affordable coverage, developing a statewide clinical health information exchange, assuring an adequate supply of health care professionals, and addressing specific health care conditions that are so prevalent they warrant special attention. The Commission provides a one-stop policy shop for the

state's health care leaders to collaborate, and provides an organizational platform to manage other programs, such as the state's Community Healthcare Access Program and the Delaware Health Information Network, Delaware's regional health information organization.

Community Healthcare Access Program

The Delaware Health Care Commission's Community Healthcare Access Program (CHAP) helps find low-cost health care services for uninsured people with incomes below 200 percent of poverty. A network of community care coordinators links people who lack insurance to a medical home or, if eligible, with public coverage programs like Medicaid. Medical services for CHAP enrollees are provided through community hospitals, community health centers, and a network of more than 500 private physicians who participate in a voluntary initiative program (VIP), a program operated by the Medical Society of Delaware. In 2007, a new component was added to the CHAP program to improve health status by implementing a health promotion and disease management component, focused on high-risk and high-need patients. Over the past year, program improvements have focused on smoking cessation, services for diabetics, and flu shots for asthmatics.

Since the program was created in 2001, CHAP has served over 21,000 uninsured patients and enrolled nearly 3,800 in other state and federal medical assistance programs such as Medicaid and the Veteran's Administration, which are significant numbers for such a small state. CHAP was initially funded through a grant from the federal Health Resources and Services Administration. Today, the program is funded by revenue from the state's tobacco settlement. In addition, AstraZeneca, a Delaware-based pharmaceutical company, provides

financial support to augment CHAP by providing “health navigators” at various community sites. The health navigators work as case managers to help the uninsured access health care facilities and services.

Delaware Health Information Network

The Commission also oversees the Delaware Health Information Network (DHIN). DHIN is recognized as a leader in the development of a statewide clinical information exchange network. In 2007, it was the first health information exchange (HIE) to successfully connect with the federal government (Federal CONNECT) and another HIE in the Nationwide Health Information Network (NHIN) trial implementations (CareSpark). The intent of DHIN is to enhance patient safety and quality of care by providing a patient-centric historical record from multiple health care providers at the time and place of care, including hospitalizations, clinical reports, and test results. As of October 2008, DHIN is currently receiving more than 80 percent of lab tests and hospital admissions and makes them available through secure results delivery and patient-record search to nearly 1,500 authorized providers throughout the state. DHIN is currently implementing electronic order entry from an electronic health record, transcribed reports, and radiology images. DHIN is supported financially with state funds, private payments, and federal contracts with the Agency for Healthcare Research and Quality (AHRQ) and the NHIN.

Health Professional Workforce Development

The Commission also administers programs created by the General Assembly to ensure an adequate supply of health professionals. This is particularly important given the state’s reliance on physicians to volunteer to see patients enrolled in CHAP. The Delaware Institute of Medical Education and Research (DIMER) and dental counterpart (DIDER) provide financial support to Jefferson Medical College, Philadelphia College of Osteopathic Medicine, and Temple University in exchange for reserved admission slots for Delaware students. Scholarships and tuition supplements are also available to the students. The Commission also administers a Student Loan Repayment Program to recruit health care professionals to federally designated health professional shortage areas throughout the state.

Conclusion

Delaware has created an orderly process to engage health system challenges and seek solutions. The Health Care Commission brings together multiple health system stakeholders regularly to consider how the state can improve health system performance. Recently, the focus has been to help uninsured residents navigate the state’s health care safety net, linking them to low-cost care or, when possible, health insurance coverage. According to the *State Scorecard*, Delaware is doing well on access-to-care measures, even as it performs in the middle among states in terms of access to health insurance. State officials acknowledge that the current situation is second-best, and express optimism that expanding coverage will again become financially possible for the state as the economy begins to recover.

NOTES

- ¹ The 13 states in the top quartile of overall health system performance on the *State Scorecard* are Vermont, Hawaii, Iowa, Minnesota, Maine, New Hampshire, Massachusetts, Connecticut, North Dakota, Wisconsin, Rhode Island, South Dakota, and Nebraska.
- ² Examples of statewide, multi-stakeholder organizations that collect and report health information include the Iowa Healthcare Collaborative, Massachusetts' Quality and Cost Council, Minnesota's Institute for Clinical Improvement, Vermont's Blueprint for Health, and the Wisconsin Collaborative for Healthcare Quality.
- ³ 2006 Health Care Affordability Acts (Acts 190, 191), Appropriations Bill, Sorry Works! (Act 142), Safe Staffing and Quality Patient Care (Act 153); 2007 Corrections and Clarifications to the Health Care Affordability Acts of 2006 (Act 70), An Act Relating to Ensuring Success in Health Care Reform (Act 71); 2008 An Act Relating to Health Care Reform (Act 203), and An Act Relating to Managed Care Organizations and the Blueprint for Health (Act 204; and An Act Relating to Health Care Reform (Act 61), and An Act Relating to Containing Health Care Costs (Act 49).
- ⁴ H. M. Leichter, ed., *Health Policy Reform in America: Innovations from the States* (Armonk, N.Y.: M. E. Sharpe, 1997).
- ⁵ K. E. Thorpe, "Vermont's Catamount Health: A Roadmap for Health Care Reform?" *Health Affairs* Web Exclusive, Oct. 16, 2007, w703–w705.
- ⁶ Vermont Household Health Insurance Survey: http://www.bishca.state.vt.us/HcaDiv/Data_Reports/healthinsurmarket/2008VHHIS_Comprehens.pdf.
- ⁷ Vermont state officials believe the increase in the military as primary source of coverage can be attributed to continued deployment of Vermont residents to Iraq through the National Guard.
- ⁸ State of Vermont Agency of Administration, "Overview of Vermont's Health Care Reform" (Oct. 2008), p.6.
- ⁹ Uninsured means: 1) you have insurance which only covers hospital care or doctor's visits, but not both; 2) you have not had private insurance for the past 12 months; 3) you had private insurance but lost it because you lost your job or your hours were reduced, you got divorced, you have or are finishing COBRA coverage, you had insurance through someone else who died, you are no longer a dependent on your parent's insurance, or you graduated, took a leave of absence, or finished college or university and got your insurance through school; 4) you had VHAP or Medicaid but became ineligible for those programs; 5) you have been enrolled for at least six months in an individual health insurance plan with an annual deductible of \$10,000 or more for single coverage or \$20,000 or more for two-person or family coverage; or 6) you lost health insurance as a result of domestic violence.
- ¹⁰ Thirteen states guarantee issue in the small-group health insurance market. Among the states profiled in this paper, those in the Upper Midwest (Iowa, Minnesota, Wisconsin) do not require guaranteed issue, but the rest do (Delaware, Hawaii, Massachusetts, Vermont). Twelve states require community rating, which means health insurance premiums cannot vary based on health status, including two of the states profiled in this paper, Massachusetts and Vermont (Source: <http://www.statehealthfacts.org>).
- ¹¹ Thorpe, "Vermont's Catamount Health," 2007.
- ¹² The original care management model for diabetes was based on the Chronic Care Model developed by Ed Wagner at the MacColl Institute for Healthcare Innovation.
- ¹³ BISHCA Division of Health Care Administration Hospital report cards: <http://www.bishca.state.vt.us/HcaDiv/hcdefault.htm>.
- ¹⁴ Vermont hospitals now will not bill for air embolism-associated injury, artificial insemination/wrong donor, incompatible blood-associated injury, medical error injury, retention of foreign objects within a patient, wrong-patient and wrong-site surgery and wrong surgical procedure.
- ¹⁵ Commonwealth Fund *State Scorecard on Health System Performance*, 2009.

- ¹⁶ See D. McCarthy, K. Mueller, and J. Wrenn, *Kaiser Permanente: Bridging the Quality Divide with Integrated Practice, Group Accountability, and Health Information Technology* (New York: The Commonwealth Fund, June 2009).
- ¹⁷ C. Chen, T. Garrido, D. Chock et al., “The Kaiser Permanente Electronic Health Record: Transforming and Streamlining Modalities of Care,” *Health Affairs*, March/April 2009 28(2):323–33.
- ¹⁸ Kaiser Family Foundation, “Health Insurance Coverage of the Total Population, States 2006–2007, U.S. 2007,” accessed on <http://www.statehealthfacts.org> (Aug. 2009).
- ¹⁹ P. Damiano, “Health Insurance Coverage in Iowa and State-Level Options for Change,” presented to the Iowa Medical Society’s Task Force on Iowa’s Health Care Infrastructure (Sept. 2007).
- ²⁰ P. Damiano et. al., “First Evaluation of the IowaCare Program,” The University of Iowa Public Policy Center and Center for Evaluation Research (Dec. 2008).
- ²¹ S. Silow-Carroll, *Iowa’s 1st Five Initiative: Improving Early Childhood Developmental Services Through Public-Private Partnerships* (New York: The Commonwealth Fund, Sept. 2008).
- ²² Governor Tim Pawlenty, “*The Minnesota Way, Modern Healthcare* and The Commonwealth Fund (Jan. 2009).
- ²³ Minnesota Health Department Health Economics Program (“Distribution of Minnesota Population by Primary Source of Insurance Coverage, 1998 to 2006” (updated July 2009).
- ²⁴ Minnesota Department of Human Services, “Minnesota Health Care Programs” (Dec. 2008).
- ²⁵ Minnesota levies a 2 percent provider tax on physicians, hospitals, surgical centers, and wholesale drug distributors; and a 1 percent premium tax on health maintenance organizations, nonprofit health service plan corporations, and community integrated service networks.
- ²⁶ For one example, see D. McCarthy, K. Mueller, and I. Tillman, *HealthPartners: Consumer-Focused Mission and Collaborative Approach Support Ambitious Performance Improvement Agenda* (New York: The Commonwealth Fund, June 2009).
- ²⁷ D. McCarthy, K. Mueller, and J. Wrenn, *Mayo Clinic: Multidisciplinary Teamwork, Physician-Led Governance, and Patient-Centered Culture Drive World-Class Health Care* (New York: The Commonwealth Fund, Aug. 2009).
- ²⁸ There is growing evidence that the physician-led, integrated group practice model is particularly effective in achieving high value in terms of improving quality and controlling costs. The Commonwealth Fund recently highlighted high-performing health systems in the Midwest, including two integrated systems of care serving patients in Minnesota: [Gundersen Lutheran Health System](#), a physician-led integrated system; and the [Mayo Clinic](#), the world’s oldest and largest integrated multispecialty group medical practice. (These case studies are available on The Commonwealth Fund’s Web site.)
- ²⁹ Minnesota Advantage organizes primary care clinics into risk-adjusted cost tiers and provides financial incentives for employees to choose lower-cost providers; reduces office visit copayments if an employee participates in a health assessment; provides disease management programs; reports MN Community Measurement quality information; and participates in the Bridges to Excellence physician pay-for-performance program.
- ³⁰ R. L. Kane, P. Homyak, B. Bershadsky et al., “Patterns of Utilization for the Minnesota Senior Health Options Program,” *Journal of the American Geriatrics Society*, Dec. 2004 52(12):2039–44.
- ³¹ The initial seven payment baskets include diabetes, preventive care for children, preventive care for adults, asthma care for children, obstetric care, low back pain, and total knee replacement. The Institute for Clinical Systems Improvement is working with the Minnesota Department of Health to facilitate seven working groups that will recommend detailed definitions for each basket of care.

- ³² S. Long and P. Masi, “Access and Affordability: An Update on Health Reform in Massachusetts, Fall 2008,” *Health Affairs* Web Exclusive, May 28, 2009, w578–w587.
- ³³ J. McDonough, “Massachusetts Health Reform: Bragging Rights and Growing Pains,” Alliance for Health Reform and Kaiser Family Foundation transcript (May 19, 2008).
- ³⁴ Suffolk University, “Poll Reveals Disconnect on Mass. Health Reform,” Press Release, poll results from June 4–7, 2007: <http://www.suffolk.edu/20588.html> (accessed June 2009).
- ³⁵ R. Blendon, T. Buhr, T. Sussman et al., “Massachusetts Health Reform: A Public Perspective from Debate Through Implementation,” *Health Affairs* Web Exclusive, Oct. 28, 2008, w556–w565.
- ³⁶ Health Connector Authority, “Health Reform Facts and Figures” (June 2009): <http://www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/About%2520Us/News%2520and%2520Updates/Current/Week%2520Beginning%2520March%25209%252C%25202008/Facts%2520and%2520Figures%25203%25202008.doc>.
- ³⁷ Commonwealth Fund *State Scorecard*: 7.3 percent of Massachusetts needed to see a doctor in the past year but could not because of cost, compared with 12.6 percent among all states on average.
- ³⁸ Defining “fair and reasonable” was assigned to the state’s Division of Health Care Finance and Policy, which promulgated regulations in 2006 assessing employers if they do not contribute at least 33 percent of premium costs for employees or do not cover at least 25 percent of eligible employees. (This requirement is exceeded by prevailing Massachusetts insurance carrier standards in the small group market.)
- ³⁹ J. McDonough, B. Rosman, M. Butt et al., “Massachusetts Health Reform Implementation: Major Progress and Future Challenges,” *Health Affairs* Web Exclusive, June 3, 2008, w285–w297.
- ⁴⁰ Commonwealth Care is not available for every uninsured person with an income below 300 percent of poverty. Lower-income workers with access to employer-sponsored coverage are ineligible, even if the employer-offered insurance is unaffordable to them.
- ⁴¹ Information about Commonwealth Care income eligibility levels, benefits, and costs are described on the Health Connector website: <http://www.mahealthconnector.org>.
- ⁴² Individuals must have insurance that covers “comprehensive health benefits” defined by the Connector; contains no annual or per-sickness benefit maximums or fee schedules for indemnity benefits; limits deductibles to no more than \$2,000 for individuals and \$4,000 for families, limits drug deductibles to no more than \$250 for individuals or \$500 for families; and includes an in-network out-of-pocket maximum of \$5,000 for individuals or \$10,000 for families.
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- ⁵⁶ Wisconsin has more than 20 health maintenance organizations operating in the state’s private insurance market, five of which were ranked among the 40 highest-quality plans in the nation by the U.S. Agency for Healthcare Research and Quality (AHRQ) and *U.S. News and World Report* in 2008.
- ⁵⁷ Wisconsin created its benchmark plan using the flexibility to vary Medicaid benefit packages provided in the federal Deficit Reduction Act of 2005 (DRA).
- ⁵⁸ State of Wisconsin BadgerCare Plus enrollment reports: <http://dhs.wisconsin.gov/badgercareplus/enrollmentdata/BCStateuly09.pdf>.
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