Aiming Higher:
Results from a State Scorecard on Health System
Alliance for Health Reform
June 15, 2007

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

[START RECORDING]

ED HOWARD, JD: I want to welcome you to this briefing on the U.S. health care system and how it is performing state by state. Our partner today is the Commonwealth Fund, a century-old philanthropy based in New York City that has been focusing as much attention as anyone has on the health sectors' performance in the past few years.

Karen Davis isn't with us today, but Cathy Schoen from the Fund will be speaking to you in a moment and making the main presentation. The Fund's commission on a high-performance health system, which is chaired by Jim Mongan, whom some of you know, head of the Partners Health Care system in Boston, has overseen much of that work in recent years, including the report that is the occasion for our briefing today.

Now, in health care, as in other human endeavors, if you want to improve something, you've got to first measure it. And last year, the Commonwealth Fund, under the auspices of the commission, compiled a scorecard on the nation's health care system and documented a lot of areas where improvement was clearly possible. And now they have taken the next step, looking at data from each of the states, allowing a comparison of how each state is doing in areas like quality of care, cost of care, access to care.

You are going to hear from respected analysts who come from states rated highly, states rated not so highly, about why the results came out the way they did, what gains are possible, if we can take advantages of these opportunities for improvement, and what steps are being taken to begin that improvement. So you have a copy of the report from Commonwealth in your packets. It's the perfect jumping-off point for our discussion today and it's one of the main items you will find in those materials along with much greater biographical information than you will get from the moderator about each of our distinguished speakers.

That is also a trigger for me to tell you that in your packets you will find materials that will be posted on our Web site. In fact, most of them are already on our Web site, allhealth.org. Kaisernetwork.org is webcasting today's briefing. It will be available, I gather, at noon on Monday and a few days after that, you will be able to get a transcript and a podcast and God knows what other kind.

Commonwealth is packaging this as - what are they called, Ann? The e-forum, in which you will be able to view the person, view the slides and listen to the audio on a very concise and user-friendly way. So watch for that as well.

At the appropriate time, I want you to fill out the question cards, the green cards in your packets, or come to one of the microphones that are set up for you to ask a

question orally. And of course, the dreaded blue evaluation form that we ask you to fill out, I want you to single it out, if you would, for later attention.

Now we do have a very distinguished line-up of speakers today, so I ask you please to turn your cell phones to vibrate or whatever it is you do, and let's continue this discussion uninterrupted, starting with Cathy Schoen.

I mentioned that Commonwealth is the co-sponsor of today's briefing. And representing the Fund today and serving as our lead-off speaker is their senior vice president and research director for the commission that I mentioned, Cathy Schoen. She has been one of the top health policy analysts in the country for many years. She was one of the lead authors of the Aiming Higher report that occasions this briefing, and we're very pleased to welcome you back, Cathy.

CATHY SCHOEN: Thank you, Ed. My mic is not on. I'm delighted to join you today, on behalf of my co-authors and the Commission on a High Performance Health Care System, to present the results of our state scorecard. As Ed mentioned, you all have a copy of the report in your folders. I want to also draw your attention to our Web address, which is on the front page of everybody's handouts. Because you will find on our Web a data compendium set of tables that gives you all the indicators, including the equity indicators, and for

every state we have done a two-page profile of the state, and so you can click on a map and download your own state to look at how it compares with other states.

The scorecard that we're presenting the results on today, builds off the national scorecard that we released last September, which found considerable gaps in getting value out of our $2 trillion-dollar investment in the health care system. Following the lead of that national scorecard, we are producing a report that aims at focusing on opportunities to improve and stimulating action at both the national and at the state level.

We use 32 indicators to compare states and we're comparing to benchmarks that draw from the range of variation within states. We have clustered for the first time in this scorecard a set of indicators that spans all five core dimensions of health system performance: access, quality, cost as measured by avoidable hospital use and costs, healthy lives, and equity, all in one report. To, to look the states and compare the states, we clustered into each of those five dimensions are 32 indicators and then we rank states on the indicators. The average rank within the dimension determines the dimension rank. Then we average the dimension ranks to get an overall score.

You have an overall ranking of the states. You have a map that was distributed to you in addition to the charts

that you had as handouts that gives a sense of the way we have looked at it throughout the report. The top quartile of states are exhibited throughout the report as white, and as you could move down the quartiles, the bottom quartile of states is the darkest color.

Overall, our findings are summarized on this chart. We find remarkable variation across the country, often a two- to threefold variation in such indicators as the percent uninsured, the percent of adults getting preventive care, the percent of admissions to the hospital for potentially preventable causes and preventable premature death rates from deaths and conditions amenable to health care.

The leading states on the top quartile of states consistently outperform the lagging states across multiple indicators and multiple preventions, suggesting that policies and systems, health care systems, are linked to better performance. Access and quality throughout the report are closely correlated. However, on costs we do not find a systematic relationship. We find instances of high-quality states that are also low-cost states. Looking across the states, we find that all states have room to improve. Indeed, on some indicators even the best scores are well below where we think they could be. In fact, we know they can be from model health systems within some of these states.

The gaps and variation across the states amount to considerable losses in terms of human lives and economic cost to the nation. We've provided indicators that allow us to estimate the potential gain to the nation if all states move to the top rate achieved by the top states. To give you a few examples, if all states moved to the top rates, we would have 90,000 fewer deaths per year before age 75 for conditions amenable to health care. We would have 22 million additional adults and children insured, which would represent a cutting in half of the numbers uninsured. Nearly 9 million older adults would get preventive care. Nearly 4 million additional diabetics would get basic preventive care. We could have a million fewer admissions to the hospital potentially preventable admissions for savings per year for Medicare of $5 billion dollars, and if all states, high-cost states, could just move to the average of Medicare average rates, the nation could save $22 billion dollars a year alone in Medicare.

Looking at the state map as I turn to the results, one of the things you will see throughout the report is a theme of regional variations and clusters of states. Overall, Hawaii, states in the upper Midwest and New England perform the best across the dimensions. In this somewhat complex chart, what you will see is for each of the five areas of performance for our indicators, again, we've

followed this theme of white is the top quartile and the darkest color is the lowest quartile, you find a pattern in the top quartile of states doing well in multiple dimensions. And down at the bottom quartile, states doing poorly in multiple dimensions.

A shared characteristic of the top performing states is very low rates uninsured. They are among the lowest rates in the country. Conversely, a shared characteristic of the bottom performing states is they have among the highest rates uninsured in the country. These states tend to be concentrated in the South.

Turning to access, we included four access indicators in the report. Two are adults and children's insurance rates and we also included the percent of adults who say they go without care due to cost. The access ratings, rankings across the states closely track insurance status of their populations. The maps across the country for adult and children and the trends over time tell a very compelling story. As you look at the adult map of the last five years, we are losing states with low rates uninsured and gaining states with high rates uninsured. The number of states with 23-percent or more of their adults uninsured has jumped, tripled from four to 12, and the number with fewer than 14 has dwindled as employer coverage becomes less affordable, costs outstripping wages.

In contrast, when you look at the map for children, we get almost the mirror image. Thanks to the federal government moving first to expend Medicaid and then to provide additional support for states through the state health children's un-insurance program, states responded and expanded and you see far fewer states with high rates uninsured and far more states with low rates uninsured. We now have 12 states that are under 7-percent uninsured. And in some of these states that have achieved dramatic improvement, such as Alabama, there remain very high rates of adults uninsured, but Alabama has really joined the leading states un-insurance.

On quality, we've group our indicators into three clusters, getting the right care indications that people are getting care according to guidelines. Coordination care, we have three indicators on how well care is coordinated in patient-centered care, where we have four indicators for a total of 14. In patient-centered, we include nursing home care. The map of the country, for quality shows states in the upper Midwest and Northeast doing particularly well, in the top quartile, four of the states who are doing well in quality, Massachusetts, Iowa, and Rhode Island and Maine, are also among the top five states for access.

Indeed, one of the themes we see running throughout the scorecard is this close correlation of access and

quality. States that do well on access are also doing well on quality. And I want to point out that this is quality across the board, including hospital clinical quality indicators. The states that are doing well in access are doing better on those as well.

When we turn to specific quality indicators, however, there is substantial room for improvement in all states. When we look at basic preventive care, even the best states for older adults, adults over age 55 don't do as well as we would like them to do. Only 50-percent of adults in Minnesota, for example, the top ranked states, say they got basic cancer screening and flu shots according to the periodicity that is recommended. Similarly, the best rate for diabetics getting three core services per year is in Hawaii, where only 65-percent of diabetics say they get the care they need. Even with these low overall average rates, though, there is substantial variation across the states, with almost a twofold variation between the top states and the lowest states.

On children's immunization rates we are doing much better in general, but there is a 50-percent gap between the leading state, Massachusetts where 95-percent of children are immunized, and lagging states where 70-percent or fewer are immunized. When we look at hospital quality indicators, as I

mentioned earlier, there is substantial variation on these as well.

On AMI, these are basis process indicators, well-agreed standards on what should happen to you when you enter the hospital. The distribution is quite close together across state averages, but you see quite widespread on congestive heart failure and pneumonia. Within these states we can now benchmark to the best 10-percent of hospitals, so states can both look at each other and look at what high-performing hospitals are doing to try to bring up these scores.

On an indicator of getting antibiotics before and after surgery, according to guidelines, we also are seeing extraordinary variation across states, with almost a twofold difference between the top state, Connecticut, and the lowest statewide averages. On coordination of care, which is critical for making sure that errors don't happen, as you move across sites of care, make sure we don't duplicate tests. We all avoid complications. On such frail patients such as congestive heart failure patients, we see a failure to do basic discharge planning such as written instructions. Where on average only 50-percent of hospitals are giving such discharge instructions. Again, on this hospital indicator, there are wide variations across the country.

The report includes all the lists of top performing and lower performing states, so I'm not going to list them now. But I want to point out for children with a medical home which is being attached to a doctor, a primary care practice that coordinates you car is accessible, we get extraordinary variation. Where children live matter, where people live in nursing homes also matter for both pressure sores and un-restraints. We allocated indicators of failures to provide the right care that could result in potentially preventable hospitalization to our potentially preventable hospitalization category and cost, because these failures, failures to coordinate, to manage care, to keep diabetes under control, both drive up costs and put patients as risk.

The map of the country for this particular set of indicators, if you compare it for others, is somewhat different. States in the Northwest do particularly well, as do the upper Midwest states in keeping people out of the hospital and preventing disease. There is extraordinary variation on states on potentially preventable admissions to the hospital. I haven't included on this slide, but you will see in the handouts the variation on children asthmatics ranges from a low of 50 to - per 100,000, to 300 per 100,000, a sixfold variation. We see a two- to threefold variation across states on 30-day readmissions to the hospital, going into the hospital, coming back again in 30 days. On

admissions to the hospital for nursing homes, on readmission rates within 90 days for nursing home patients, leave the hospital, go to the nursing home, come back again in three months. This type of churning drives up costs and puts patients at risk.

Across states as measured by Medicare total cost per beneficiary, there is a high correlation between avoidable hospital use, here measured by the 30-day readmission rate and higher costs overall. I think this is symptomatic of duplication, of poor use of resources, as well as failures to manage care well in the community and primary care. And we see a consistent pattern across the states.

States with high rates of 30-day readmission have costs of Medicare that are 38-percent higher than states with the lowest rates. We estimate that Medicare alone could save as much as $5 billion dollars a year from reducing these avoidable hospitalization rates. Turning last to the last two dimensions on healthy lives, we have a set of five indicators that are sensitive to both health system performance and health care - public health policy performance. But on healthy lives we know that lives are also affected by poverty, by working conditions, by environmental conditions, by migration in and out of the state. The indicators we have selected, however, are because they're sensitive to the way the health system performs and

how public policy performs, are benchmarks and bellwethers for the states to be looking at as they seek to improve performance. These indicators should also improve. One bellwether overall composite measure is mortalities amenable to health care. These are deaths before age 75 from diseases such as diabetes, infections, heart disease, and the screenable cancers. We see an extraordinary variation across the states, with the lowest rate state, Minnesota, being 70 deaths per 100,000, ranging as high as 150 per 100,000. And you can see the quartile range across the states and the concentration of high rate states.

We used many of the indicators in our report, 11 of them overall, to also look at equity within states. We looked at equity for three vulnerable population groups, low income, adults within the state uninsured, and Black and Hispanic minority, and other minority groups within the state. Our equity indicators compare each of the vulnerable groups to the national average for the whole population, so we're using an absolute standard of the gap between the vulnerable group and the national average. To give you just some highlights of the equity findings, we found a consistent story across states of high-income adults doing generally better than low-income adults, of the insured doing better than the uninsured, with very large gaps between insured and uninsured. But in states where the low-income populations

were doing well and the uninsured were doing well, we also found that the high-income populations and insured populations tended to be doing better at all. There are often statewide patterns. We have some states where the high income and insured are doing less well than the low income in other states, indicating that we really need a systematic approach in some states to bring performance up.

On mortality amendable to health care, we were able to look at whites compared to blacks. The black mortality rate on this premature deaths before 75 indicator is more than twice that of whites, with significant gaps across all states where there are enough black and white population mix to be able to do the comparisons. In the lowest rated states, where the rates are low for whites, the rates tended to be lower for blacks as well, with a lower gap between the groups. We see significant variation across states on the White rates, ranging from a low of 68 per 100,000 in Minnesota to high 118 per 100,000 in West Virginia.

On some of the states where black rates are high, the white rates were also high, well above the national averages.

To sum up, as I turn to my other panelists for responses, we think, looking across the states, there is an urgent need for action and for taking a whole system view with an emphasis on population health, four core messages come out in terms of the need for policy action. The first

is the critical importance of extending insurance to all - that correlation between access and quality cuts across the states. We need insurance to get to basic, more effective care, more efficient care. And I think the map between children and adults indicate we need - there is a national, a strong national role here. We need the federal government to lead so states can also respond and act. The wide variation across states points to opportunities to learn. We can look at what policies national, state and local, as well as private sector system variations led to these and each learn from each other.

We have enormous information gaps within states and across states. We don't know much about safety. We don't know much about care outcomes, how well are diseases controlled and other outcome measures. None of the states or the nation have good IT information systems that could both support physicians in their decisions but could also allow us to track population health and know more about outcomes.

And finally, we need national leadership and state leadership and collaboration before - across public and private sectors. By working together with a coherent set of policies there is much at stake, but we also have ample evidence that the nation can improve across triple aims, a better access, better quality and better value for our health care dollar. Thank you.

[APPLAUSE]

CATHY SCHOEN: And I don't want to take any time on this but the last couple of charts, thank my co-authors. This was an extraordinary team effort and many of those are in the audience in terms of both getting the report out and reviewers. Some of the reviewers are also on the panel.

ED HOWARD, JD: An impressive assembly of information and evidence. And since it is a report on the states, we are going to hear from people with a particular state point of view now, the first of whom is Peter Budetti, who is currently on the faculty of University of Oklahoma College of Public Health. He's held similar posts at Northwestern and GW University here in Washington. Some of you may remember he served a stint on the professional staff of the House Energy and Commerce Committee a while back. You may not know that he is somebody who both holds a law degree and is a pediatrician as well.

So, Peter, thanks for coming across the country to be with us, and we are looking forward to your presentation.

PETER BUDETTI: Thanks, Ed. And welcome, everybody. I am very pleased to be able to listen to the Commonwealth Fund's report, which once again [Short interruption due to technical] Whoever, the chairman often controls the [Laughter] -

ED HOWARD, JD: Not guilty, your honor. [Laughter]

PETER BUDETTI: Thank you. The Commonwealth Fund I think is on a very useful job in terms of helping us focus in a way on not only what the problems are, despite the massive expenditures for health care in this country, but also what some of the potential solutions might be and helping us point the way towards action. And my message from Oklahoma is that first of all, within the state borders, we are well aware of the fact that we have some issues that we need to deal with. We hadn't publicized it around the country until today, but we are well aware of the issues, and I am going to show you some of the background on that in a minute.

But I really have a very encouraging message, which is that there is tremendous level of public and private sector involvement in our state to try to deal with these issues and I think that is a very positive sign and I think the Commonwealth Fund report will really provide a useful tool for helping us to do that.

First, I have to acknowledge my colleague, Mike Lapolla, who was responsible for some of the pretty pictures. And this is - our approach to this which is that we have known about these problems for some time. You know, this is our long-standing issue in Oklahoma. That is hurricane warnings for Oklahoma. Of course, it should really be tornado warnings. But for 10 years, our state board of health has been telling us, issuing a state of the state report that has

been showing us things like this. That age-adjusted mortality in Oklahoma which used to track the national rates suddenly separated from the national rates a number of years ago, and that as we came into the 21st century, we were left behind. And our age-adjusted mortality rates have not gone down at the rate that the rest of the country has gone down.

So we have been tracking this. We have been aware of our problems for some time. Of course the United Health Foundation has been pointing it out to us as well. Years ago we were in the middle of the pack and in the last decade or so we have been towards the bottom. Most recently - this is not one of your slides. I just put this in this morning. I love, you know, PowerPoint. But the Agency for Health Care Research and Quality's new report puts us in the weak zone and even more troubling below our baseline year. So - and this is - this is the way that we have been looking at this, which is that a couple of decades ago our state really looked like a Southwestern and Midwestern state by a number of health indicators. And over time, has really become much more akin to the profile of the Southern states. And so the region of the country that has had the most serious problems for some time, unfortunately, we are now in that same category.

Why? So why are things so bad? Well, we have been looking at this in some detail. This is the report card that

our state board of health issued. I don't think any of you would want to either bring home a report card that looked like this or have your kids bring one home to you, where pointing out to us that - these are all different measures and by and large in almost every category, the dominant grade that our state board of health has been giving our state has been an F, that we have not been eating well, exercising much, there is a high rate of smoking, in the state there is a lot of injuries and of course when you get to the bottom - disease prevention is not so bad - when you get to the bottom, we have a terrible problem with access to care. We have one of the highest rates of un-insurance in the country. So we are well aware of all of these things.

Why, again. Well, Oklahoma experienced substantial declines in relative wealth over the last few decades compared to the rest of the country. And you can see that in the most recent report, we were down at 44th in terms of household income and over time - this is a wealth index. You can see that over time the relative wealth has declined substantially in the state compared to the rest of the country. There is a little tick up there at the end that we are very hopeful will continue of course in the state. And very closely correlated with that is the decline in our health index as well. So we really do think that, no

surprise, one of the main factors is low income is accompanied by poor health.

Now here is what I really wanted to talk about, are some of the things that we are doing in Oklahoma to address this. And the two groups of activities that I want to mention briefly. One is a set of activities related to access and one is a couple of things that are going on in terms of trying to improve the overall health of the population. We have this small business subsidy program called O-Epic that has been growing. Enrollments have been increasing steadily but they are not up to big numbers. They are only up to about two-and-a-half thousand in most recent data. But they have been growing steadily. But what the encouraging sign is that - and the way the program works is that the government pays 60-percent and if the employer will pay 25-percent, and then the employee only has to pay 15-percent.

Now, this had been a program for very small businesses and it was expanded to size 50 and most recently in a remarkably bipartisan move by the legislature and the governor, it has now been expanded to 250 businesses, up to 250 employees, and from a 185 percent of federal poverty level to 250-percent of poverty.

So we have really made a tremendous - this is just signed, just signed into law recently and the waiver is right

now being prepared to submit to CMS for approval. So we have a unique political situation in Oklahoma. The Democrats that controlled the legislature for many years term limited out of office, so now we have a divided Senate that is split right down the middle, and we have a Republican controlled House. We have a Democrat governor. And so we really have achieved some bipartisan progress not only in expanding the O-Epic but also in expanding coverage for kids. Again, this is a very recent development that is going to allow coverage for perhaps as many as another 40,000 kids in Oklahoma.

So those are both extremely encouraging both because they happened and also because they happened in a bipartisan way, which I think augurs well for the future. Our insurance commissioner has been catalyzing a wide range of initiatives that are very intensive. She put together public/private task forces that met over a two-year period and produced 10 strong recommendations all of which are now being incorporated into an action plan. She is about to embark on a state wide campaign to have people in communities all over the state of Oklahoma use the chat way of thinking about health care coverage and trying to decide - I don't know if any of you are familiar with this but it is a very useful tool for helping people realize how you need to allocate resources that are limited across different aspects of health

coverage, and basically to try to elevate the level of pubic discussion around the state.

Just going back, we are talking about 41 town halls and 31 communities. I've got six of our graduate students who are going to be working with her on this, and she is going to conduct five town halls all around the state later this year. We raised tobacco taxes. We raised tobacco taxes a few years ago and also in a very creative way, restricted smoking in restaurants. And this is very important in our state because we have one of the highest rates of smoking addiction in the country. And this was a major breakthrough for us to try to not only generate some revenue, but improve health.

The latest thing that I wanted to mention was the governor's new initiative, a strong and healthy Oklahoma. This is patterned very much after the same activity in Arkansas, our neighbor state to the east, for those of you who have not looked at a map of the United States for a while. And this is an attempt at - there are several hundred thousand copies of this. There is a big push to expand knowledge about what eating better, getting more exercise and stopping smoking, what the resources are to help people do that. And that is what this is all about.

This is a slide that you don't have in your folder, but I put it in just because I wanted to point out that when

we compare states to each other, we sometimes lose sight of the fact that states are really very different. And this is a comparison that we did recently, because we had been talking about whether we could have a new state that we call "Oklachusetts" and have a health reform for universal coverage like Massachusetts did. And you get a sense, if you look towards the bottom here, we have about the same number of uninsured people. But if you look at the top, our population is half the size of Massachusetts. And our state resources are much lower, much fewer, and our federal flow of funds is also much lower. So we are in a very different position to try to do something like that.

The bad news is we know that we have problems and we want to do something about it. And I think the good news is that there really is momentum in the state that is trying to address this, so - I'm only 26 seconds over? I'll be happy to quit at this point. Thank you all very much.

ED HOWARD, JD: Thank you, Peter.

[APPLAUSE]

ED HOWARD, JD: Very enlightening. We are going to continue our tour of the states, swinging to the Northeast if we will. Chris Koller is the health insurance commissioner in Rhode Island. He is the very first person to hold that position, as a matter of fact. His duties are not only to regulate the insurers in the state but to serve as the

governor's health policy coordinator as well. He has had firsthand experience running an HMO. In fact, his was the first community health center affiliated health plan to gain an excellent rating from the National Committee on Quality Assurance, which does ratings of HMOs. So Chris brings a unique blend of talents and experience to his position, and we are very pleased to have him with us to talk about the perspective of a state that did somewhat better than Oklahoma in these rankings. Chris, thanks for being with us.

CHRISTOPHER KOLLER: Thank you very much. What I am going to do is try to give you a perspective as Ed said, from a - as a sort of practitioner in the state rather than a researcher. Ed already went through my role. One advantage of being the first, I say, that when you leave you can say you are the best health commissioner the state has ever had, and I am going to stick with that while I got it.

I want to sort of start with an overview here around making sure that we have in our mind sort of the benchmarks that Commonwealth has put in front of us in some of their previous reports about what makes for a high-performing system of care. And they have identified these seven points around organizing the system for care, coordination, access, promoting HIT, pursuing excellence in quality, going for transparency in pricing quality and rewarding it, focusing on access, working on primary care and innovations, and

developing leadership and collaboration. And the point I want to make here is twofold. One is that what really makes this report unique is that the unit of measure is the state. The implication is that you can measure the system in terms of the state as a whole, and that is very valuable to us who are working in the trenches if you will.

And the second is that the denominator is the population, this notion of population-based health and population-based measurement. That is really important, especially from a policy-making dialogue that is often driven by particular interests, particular providers, particular stakeholders. If you can raise the conversation to how are we doing as a community, that is very valuable. And I want to thank Commonwealth for continuing to work on that and sort of keeping the bar high. We appreciate the ranking from Rhode Is-, or from Commonwealth in terms of Rhode Island. It is not something that we sort of puff our chests out because I think while there is a recognition that policies make a difference, there is also an acknowledgement that this is pretty complicated, and Cathy helped sort of take it apart. But you've got to keep working at these sorts of things. So what I want to do is, using the Commonwealth's reference points, just talk about what are some areas where we think we have worked particularly hard and then what are some threats that we have.

In terms of what we worked hard on, the notion that access makes a difference, there are two reasons why Rhode Island ranks high in terms of health insurance access. The first is that we have a strong tradition of employer-based health insurance - I am going to talk about that in a moment - and the second is that we moved aggressively into Medicaid managed care and Medicaid expansions early in the '90s. We did CHIP before there was CHIP in terms of a childhood expansion. We are not at 250-percent of poverty eligibility for kids and 185-percent for parents. That is under siege right now for reasons that I will talk about, but that has been very fundamental. I think the second area is this notion of the state - the state emphasis on quality. First of all, we have a lot of managed care penetration and it is written into our regs that all plans must be NCQA-certified. That is why my plan got NCQA-certified.

The second is that - and those outside standards work. The second is Rite Care, our Medicaid managed care program has a - it is the most intelligent purchaser in the state. It purchases health care for 12- or 13-percent of the state's population. It measures improvement. It does evaluation. It really drives a lot of this stuff. We have public reporting by providers. I will tell you specifically the reason why Rhode Island ranks number one in quality is the measure emphasize hospital-based quality. We have had

public reporting on quality led by our department of health, using our Medicare QYO as the facilitator for that process. It is long. It is painful to get the hospitals to agree to it, but it makes a difference.

Consumers don't choose bases on it but, boy, the provider, you improve what you measure and that is what we have been measuring. And the last is, much like other states or several other states in the Northeast, we have very strong public immunization programs. In Rhode Island, the state actually buys and distributes the immunizations itself for the doctors, rather than have the doctors do it. It is funded through an assessment on the plans on a per capita basis. We have always done well in the immunization piece.

The last area is what I will call leadership and collaboration. It is pretty easy to get together to talk about things in Rhode Island and that is important. Some - a fed referred to it as line-of-sight trust. You know, people when they call the health insurance commissioner's office with a complaint sometimes get the health insurance commissioner if I pick up the phone. And that is unusual. And when I worked in New York, there were probably 15 people who thought they had my job in New York, so it is a lot easier just to get the folks together to talk about these sorts of things and build the relationships that are important.

Now, what are some threats that we are dealing with? I want to identify four. Our basis of employer-based health insurances is eroding. This is a complicated slide. All you need to know is that on the left in the '97 we had about 230,000 people who got their health insurance as employees plus their families'. Between then and 2004 we actually gained work force, that is that next bump, the rise, and then we started losing. And the big place that we lost is the third bar from the left, that's a decline, where we lost it looks like about 40,000 - yeah, 45,000 people because of a declining eligibility. Employers are no longer covering people. They are offering it. They are no longer making those people eligible. These are part-time workers who do not qualify for health insurance. That is how they are managing their expenses and those people are not coming back on. And that leads to a declining overall insurance at a time when Rhode Island's unemployed rate was going down. That is a very serious issue for us, and it is important given what the Commonwealth Fund has found.

Our next three threats have to do with our Medicaid budget. We are one of the few states that is running a budget deficit in this era of plenty. And it is driven by our elderly and disabled population. That is politically very powerful and it requires leadership and political skills to figure out how to spend the Medicaid money efficiently.

The third threat is our primary care infrastructure. I think you are quite familiar with the idea that primary care is the only part of our delivery system where increased supply is associated with improved quality and improved efficiency, and Medicare disadvantages it. We all follow Medicare, the commercial health plans I regulate do. And Medicare's payment system systematically disadvantages primary care. They have been working on it, but we have got a ways to go.

The last area is our cost dri-, it is the underlying cost drivers. You are familiar with the costs of chronic care. That is not unique to Rhode Island. It has to do with behaviors and our ability to coordinate care to treat it, and it is driving our underlying cost of care up. It is something that our employers do not always understand. They think more competition between health plans is a silver bullet. It is not. We have to get at how we are using the resources.

So lastly, what I want to close with is what sorts of help do we need from D.C. that will continue to make our states better? The first is the fund prevention. I think that we do really well when we identify a victim or a promising new technology. Spending money on unidentified victims is not something that is politically popular but it is absolutely necessary. Having served on our state's

prevention block grant advisory committee and seeing how we scrabble for the little teensy bits of federal funds that are out there, we have got to change that equation somehow. And the second is that measurement is important. You improve what you measure, and efforts by public and private officials to measure the states, we them with providers. Consumers don't choose on this but, boy, the providers compete. And this measurement has been very well received, this effort by the Commonwealth Fund in the states because they want to see how they stack up, and continuing to create that sense of competition based on reliable measures is important.

Cathy in a prep call said five years ago we couldn't do this because the data collection was not there. And now we can, and that is really important.

The third area is Medicare innovation. Having looked at commercial payment in Rhode Island, I will tell you that Medicare's inpatient payment system is much more rational than what commercial payers do. There is only a 10-percent variation in what Medicare pays our community hospitals on inpatient basis. That means that they reward costs and they are starting to - low costs, and they are rewarding quality. Commercial hospi-, commercial payers, that variation is 60- or 70-percent, so the hospitals providing the same sets of services are reimbursed up to 60-percent differently just based on their ability to negotiate. And the more you cost

the more you get paid, which makes no sense whatsoever. We need that kind of innovation from Medicare on the primary care side as well.

The fourth is what I will call facilitated collaboration amongst stakeholders. You should have in your packet some information about a project from the Center for Health Care strategies. Rhode Island is one of the recipients for that. We are getting the payers together to have an all peer collaboration to improve primary care. We need Medicare participating in those sorts of things, and driving us to do that because our fragmented payment stream drives providers crazy and makes improvement very difficult.

And the last area is to continue to promote areas to improve health insurance access. This is the time of S-CHIP reauthorization, CHIP has been phenomenal for the health plans in terms - I mean, for the states in terms of allowing them to increase access. And when we are looking at employer-based erosion or erosion of employer-based care, the kinds of things that Peter was talking about in Oklahoma, those help but we need - the majority of the uninsured in Rhode Island, 80-percent of them have incomes less than 300-percent of poverty. They cannot buy themselves - buy that insurance by themselves even with a tax credit. Medicaid is going to have to play in that game and we are going to need the help of the feds to leverage our Medicaid money to

experiment to get people into that, in the way that they are doing in Massachusetts and in other states as well.

I think I will stop there. I am under my ten minutes. We can move it on.

[APPLAUSE]

ED HOWARD, JD: Thank you very much, Chris. That is terrific. We are going to hear last from Mary Wakefield. She is the associate dean for Rural Health at the University of North Dakota School of Medicine and Health Science. Mary is a nurse by training. She has held senior legislative and administrative positions right here in the Senate. She is one of the country's leading experts on rural health issues and not so incidentally, she is a member, a very valuable member of the Commonwealth Commission on a High Performance Health System, under whose auspices this report was produced. So Mary, thanks for coming this distance as well, and you can provide us with a perspective not only of rural issues in general and from what the commission was trying to do, but also North Dakota did pretty well in these rankings as well.

MARY WAKEFIELD: Not so bad. Thanks, Ed, and good afternoon to all of you. I am going to make comments in about four different areas. First, as a member of the Commonwealth Commission on Creating a High Performing Health System, I will tell you just a little bit about that commission and its focus. Secondly, I am going to provide

you with a bit more comparative information that reflects the variation across states, based on giving you just a couple of examples from the state of North Dakota. I won't stay long there because you have heard some really nice bookends if you will from two states, so I am not going to drill down deeply, just give you a little bit of a sense of a few of the data points from my home state. Then, given the previous speaker's discussion about health insurance coverage and a couple of other important areas, I am going to pick up on system-ness and primary care and how I see those issues relating to the findings of the state scorecard, if you will. So different areas of focus trying to build on what the previous speakers have shared with you.

I also will make a couple of comments about some of those features of system-ness and primary care that could perhaps benefit more from federal policymakers' attention.

A couple of words first about the Commission on High Performing Health System, the commission is an 18-member commission that draws expertise from a variety of areas, important areas, including experts in state and federal policy. There are members of the commission that come out of the health care delivery systems and from the business sector, from professional associations and academics as well.

The commission was instituted by the Commonwealth Fund in 2005 and the group has been directly involved in

informing the focus of both the state and national scorecards, as well as informing some other documents including a document and at least one in your packet today, and that is the framework document that I think is worth perusing on your part. You are going to continue to hear commentary and recommendations coming from the commission, on how we can collectively move forward to create a high performing health system. As this commission continues to exist these are not our - we are not involved in just these products, that is the scorecards, we will be involved in products that will be released going forward.

With that, just a couple of other slides on the commission itself, I wanted to share with you the commission's view of the mission of a high performing health system. It is highly relevant, this statement, I think to today's presentation of state scorecard results, in part because part of this statement speaks to helping everyone to the extent possible. And clearly, the scorecard findings suggest just how far away we are from deploying health care that consistently achieves the - to the extent possible - part of this particular statement.

The scorecard data make a pretty compelling case that we are a long way away from consistently achieving that end, and that for some states and for their populations on some dimensions we are frankly a long way from achieving to the

extent possible populations that will live long, healthy, and productive lives. Clearly to move forward in a substantive way, as the other panelists have indicated, it is going to take some pretty significant prompts, even disruptive changes in the way we currently do business in health care in order to achieve this mission that is a creation of high performance in health care.

The commission's view of features of a high performing health system overlap with the dimensions that are captured in the state's scorecard report, all of which fall under I think these four characteristics. And you have got a copy of this slide obviously in your packet as well. But the dimensions that Cathy shared with cluster under these four areas, which are characteristics of high quality safe care, access to care, efficient and high value care, and a built-in capacity for systems to improve and that includes, by the way, organizational capacity as well as capacity for workforce innovation.

Time limitations prevent me from commenting a lot on each one of these areas, but a point to keep in mind is that policies and strategies that are directed to just one of those areas, for example efficiency, or directed just to high quality and safety, are not going to get us to a high performing health care system. So when we think about policy changes and strategies and approaches, it is a set of

strategies that address all four of those areas. That is a big menu, a big portfolio of activity to put in front of state policy makers, clinicians, researchers, federal policy makers, and so on, but it is that complement of activities in areas of focus that the commission thinks are necessitated or is necessitated in order for us to create a high performance health system in this country.

So we need efforts in each of those areas to support moving the set of scorecard measures north on the metrics instead of south on the scale that Cathy shared with us. And I would say as you hear more from the commission and the Commonwealth, much of it will revolve around recommendations that aim higher in those four areas of focus.

So, enough about the commission itself, on to my second area, which is just a couple of data points on North Dakota. As I mentioned, you have already heard good examples of state-level data, much of it addressing access to care, rates of insurance coverage, so I just want to point out for point of comparison that in North Dakota on the front that deals with insurance coverage, we do fairly well. We have about 85-percent of our adults covered. And again, what that illustrates is that there is a lot of variation in coverage across states. That percent of insured in North Dakota is good, but it is still not good enough, because it is not as

good as the highest performing state that comes in at 89 percent of coverage.

So even here, where we in my home state do fairly well, there is still room for improvement. And I think that is a point that can be made across all states, across most of the dimensions that have been reported on the scorecard.

On a different but also an important dimension, North Dakota does quite well in terms of measures of unnecessary hospitalizations. And North Dakota also does quite well in terms of what it costs the Medicare program to provide care. With North Dakota ranked about second in Medicare reimbursement per enrollee, there are likely a lot of reasons for that kind - those kinds of findings, but I do think that it is worth noting that North Dakota is higher than the national average in terms of the number of primary care providers to population. And primary care, we think, is key to managing many things, including managing chronic conditions like diabetes and asthma. We know from the Dartmouth data and other data that states that rely more on primary care to manage chronic illness, tend to have lower Medicare spending and use fewer hospital beds. This is a critically important piece of information in terms of helping all of us to direct our attention from training programs to clinical care to public policy, with particular attention to

primary care and ways that we can support that part of the health care delivery system.

Clearly some of the - excuse me, I'm going to switch now to the third area. And that is a couple of areas of focus that I mentioned that I wanted to call out, if you will, that the commission members are focusing - oh, here are those slides. Thank you very much. Thank you. These are a couple of areas that the commission is starting to drill down on with particular attention, system-ness and primary care. And I want to make a couple of comments about both of them, because without a doubt some of the poor performance on some of the dimensions reported in this state scorecard are tied to our fragmented approaches to delivering care and paying for health care, as opposed to trying to develop and create features of system-ness and cohesion and care coordination across our health care delivery system.

To let you know that this is not a new concept, I draw you back to this slide which is a statement taken from the Institute of Medicine's report, Crossing the Quality Chasm, no doubt familiar to all of you in this room, a report that is now six years old and a committee rather on which I served. We tried to focus a lot of attention in the Chasm report on this issue of fundamental organizational and delivery problems in health care. They muck up those problems with organizing care and delivering

care really muck up a lot of what we are trying to do in terms of delivering safe, efficient, value-laden care. And I think this quote pretty well captures that sentiment. The quote was true six years ago.

The data and the state scorecard suggest that too frequently it remains accurate today. That is that our current methods of organizing and delivering care are unable to meet expectations. The science and technologies that are involved in health care, that is, the state-of-the-art knowledge, skills, care interventions, devices and drugs have just, simply put, advanced more rapidly than our ability, that is, that infrastructure that care organization has. That's the capacity of our organizations and our work force to deliver those devices, interventions and drugs safely, efficiently and effectively.

All of the great 21st century technology, science, drug therapy, skills of nurses, pharmacists, physicians and others have fundamentally been loaded onto an organizational platform that struggles mightily to support it in all of that in a way that insures that those skills, knowledge and technologies are delivered safely, efficiently and effectively.

I was flying in just from Detroit this morning and thinking about that and it struck me that an analogy might be we have terrific commercial jets in this country. We have

world-class pilots that are piloting those jets, powerful engines sitting on those wings, wonderful cockpit technology. Put that image in your mind and think of coming in for a landing at Reagan National on wagon wheels. Put that jet on wagon wheels and think about what would happen. Well, that is a little bit of an analogy of what we have got going on and what is embedded in this statement, reaching, harkening back to the IOM report. Lots of technology, lots of state of the art science loaded on a platform that is in some instances 20, 30, 40 years old and a little bit too, too, much unchanged. So the point is we need a lot more work on organizational structure and processes in order to come up consistently with good soft landings in health care.

So what to do in terms of strengthening this feature of system-ness? What might the policy focuses be for us and for Hill policymakers in particular? I've just a few comments. First of all, from my perspective, we need to keep an eye on measuring for information and measuring for improvement. And that means having a coherent set of metrics on health outcomes, metrics on access to care, quality of care and the new frontier, measures of population and community level health. The state scorecard that has been produced is a great step in that direction of providing a composite picture. But this is the first iteration. There

is a lot more work that needs to be done in both the private and the public sector.

From a rural perspective, I can also tell you that in terms of measurement and implementing change, quality improvement organizations, and so this is important to federal policymakers, play a pretty pivotal role in working with all types of providers to get information out to them about how to measure, collect data and institute appropriate changes in health care delivery. In addition, continuing this emphasis is going to be important on measurement and I would suggest that for Hill's staff you might want to constantly trying to keep your finger on the pulse of what is creating barriers to aggregating, analyzing and using data.

Harnessing the data we have available today is not easy and there are barriers that probably could be overcome with intervention at the national level just as there are barriers at the state level. Also essential to a system-ness is the deployment of health information technology and we are not there yet. We are in many respects a long way away from being there yet. That is from having the kind of activity across integrated health systems so that people have access 24/7 to information when they need it, whether it is a patient or a provider.

Then in addition, a key part of health information technology is also the deployment of telemedicine. We have

been struggling in fits and starts for a long period of time with using and deploying telemedicine effectively. But I can tell you from a rural perspective that integration and utilization is really critically important.

Finally on the - the last point on system-ness is just to say that we still need a lot more information to help us better understand how to structure the organization of health care services in this country. We need more research on health system performance and that includes the need for more health services research that focuses on how to organize care, how to facilitate communication, how to coordinate care and how to deploy team approaches to care. That strength in a research area is like comparative effectiveness but keeping a focus on those pieces of comparative effectiveness, not just comparing medical devices and biologics for example. I think it's important to think about to how to parade those wagon wheels. We are going to need research to do that.

So given that importance of system-ness and care coordination, I would encourage health staff to think about this, to think about filtering every policy, piece of legislation, program that you are evaluating through a prism that helps you to distinguish whether the policy or piece of legislation you are looking at will further fragment or splinter health care delivery and payment policy, or whether

that policy or piece of legislation could help to build system-ness and cohesion and coordination into health care.

Lastly, last comment and just briefly about primary care because I talked it about it already in the context of North Dakota, many of the indicators from the state's scorecard are sensitive to primary care, including indicators that reflect how well we are doing on chronic conditions, how well we are doing to ensure that children and adults have access to recommended screening and preventive care. We need policy focus that helps to ensure that the payment and training incentives within the too frequently fragmented delivery structure don't encourage the provision of more fragmented care, particularly for chronically ill patients.

Right now, for example, there tends to not be much reward for providing primary care. For example, there are no incentives to establish a medical home for primary care. There is precious little to incent coordination of specialty care. And so given what we know about the value added of primary care I would encourage you to once again consider whether a piece of legislation, a policy, a program that you are contemplating moves primary care closer to being an on the endangered species list of sorts, or if that legislation or program that you are considering has the capacity to strengthen the delivery of primary care. Many of the

scorecard dimensions sensitive to, I think primary care deployment of services. And that is it for me. Thanks, Ed.

[APPLAUSE]

ED HOWARD, JD: Thank you, Mary. You now have a chance to ask some questions and make some comments. There are microphones you can go to. There are green cards in your packets. If you do have to leave before the session, the Q and A session is over, I would ask you to fill out the evaluation form as you go. And let me take advantage of this transition to clarify something that Chris has said in his presentation. He talked about the difference in variation of payments to hospitals between Medicare and commercial plans, and I wonder if you could clarify what constitutes that variation and why is low variation better than high variation and what it means for Medicare policy versus commercial policy.

CHRISTOPHER KOLLER: You had me on the clock so I kind of raced through some of those slides. I think the point I was trying to draw is if you want to drive change, follow the money. Good behavior follows reimbursement. And what Medicare is reimbursing for on the inpatient basis is case-based under DRGs and they reward efficiency, they reward medical education. And they try to compensate for disproportionate care, so the DRG pays the same amount to a hospital in the same geographic setting, so we adjust for

wage regardless of your cost. So that is why when we in Rhode Island looked at Medicare payments, you have only got like a 5- or 10-percent variation for the same service. Commercial, the negotiation - it is determined by the negotiation process. And the negotiation process essentially starts with where are you now and from the health plans how much more - how much - what little increase can I afford to give you, and from the hospitals, how much more can I get from you? It is a revenue maximization, no expense, reduction.

So there is not attention paid to cost and there is actually precious little to quality, from what we can tell, much more serious measurement and thinking about quality in the paper form forum and stuff coming out of Medicare. So what we found in Rhode Island is that commercial payments, when you adjusted for the type of day for the same service among hospitals, varied by 60-percent on a - say you blended medical/surgical per day rate. So that meant, you know, simply a gallbladder operation what a commercial pay or paid varied by 60-percent for the same service depending on what hospital it was in. And you know, there is just much more rationality. So what is my incentive as a - I have no incentive to reduce costs as a hospital. I have every incentive to negotiate to maximize revenue, whereas, under Medicare, I have a stronger incentive to reduce my costs.

ED HOWARD, JD: Good explanation. Yes, would you identify yourself and try to keep your question as brief as you can so we can get through as many as we possibly can?

CAL CLARK [misspelled?]: Okay, I'm Cal Clark from the American Association for Medical Colleges, and I had a question about the differences between patients. And Peter, you brought up a lot about your health scorecard and obesity and smoking and everything, and do you think it is fair that you are confronted with a much different and a much more difficult population set, patient set, that goes into your health system, and do you think it is almost a little bit easier for Chris up in Rhode Island to have these great metrics because he has a better population, better patient set to start with?

PETER BUDETTI: I think that is always a fair question and if you look at the comparisons of our state to some other states, we might argue that we are a lot different from Rhode Island and we are a lot different than Massachusetts and some other states, but you know, we are not all that different from Kansas and from Iowa and Nebraska and Missouri, and so for us to argue with a population base, you know, of several million people that everyone in the state is different to the extent that would lead to those kinds of discrepancies, I think would be very hard to you know, to argue that point. On the other hand, we do have certain

chronic diseases. We have very high rates of diabetes. We have a number of other problems in our state that are relatively disproportionate, so I think there is some element of that, sure. But I wouldn't try to argue that our population is all that different than especially some of our surrounding states.

CHRISTOPHER KOLLER: When I teach Brown medical students I say, tell them, whenever they are confronted with data, their first response should be, "But you don't understand, my patients are sicker." And just sort of keep repeating that over and over again, and you send a measurer back to scurry for more data to demonstrate it. And half the time they are right, but half the time they are wrong. And so you know, I think to Peter's point, when you have got a large population base, it is going to even out. And the other thing is if you look at the goals that Mary set forth, the goal of the health system is a long, healthy life. That encompasses both prevention and treatment.

ED HOWARD, JD: Yes, why don't we go here and then back?

MARY GILBERTI [misspelled?]: I'm Mary Gilberti, and I direct public policy for the National Alliance on Mental Illness. And I had a question about some of the challenges in doing a report like this. The first one I had a question about was the timing of the data. I completely believe in

measuring but if you look at some of the datasets, and we have had this problem ourselves in looking at systems, the data is kind - can be older in some of these sets. And with things changing so rapidly in the states with these reforms particularly on health insurance, how do you deal with the timing of the data with what you are trying to do in measuring the states?

And my second question related to that is, sometimes you have separate systems like the mental health system, particularly for adults. It is very different in states than the primary care - or physical health system. I think it is getting better and we certainly want it go get better, but we are not quite there yet, and particularly in the adult system for Medicaid rules and other wise we are very different systems right now. When we graded the states on some of the states, we got very different results than you all did in this report. So how do you deal with the fact that on some disability groups, the systems are very different?

ED HOWARD, JD: Cathy, before you launch on that, let me just supplement that. Someone had specifically asked in addition to what has been voiced what records you surveyed in general to get these statistics.

CATHY SCHOEN: Try to address both really quickly. Page 9, it is Exhibit 1 in the report gives you the dates on the thing, and you are absolutely right. You know, we have

got a two- to three-year lag in a couple. The most recent we could get was 2001 or '02. I think that is partly the state of where we are getting data from in this country generally. We are getting better on some, CMSs, hospital quality process indicators. We can - we will be able to update this with 2005, 2006 data.

I was in a UK demonstration, just to give you a sense of when you get a really integrated system with data. The doctor there looked at his patient sitting in Boston when he coded in to find out how many the last month had been admitted to the hospital for diabetes so we could worry about the control patterns. So he said, we have got it down to a 30-day lag, when we used to be a year lag. But they have IT systems and integrated systems, so I think we have got a lag on this data, and what we hope to do is get more current and be able to update it.

But we are missing huge pieces, so the second - when we get to subsystems such as mental health, and I could name a bunch of others, we just don't have anything and we tried at the national scorecard level. We benchmarked with the best we could find with the United States and often the best we could find was one national survey. And we could not find a comparable set of state statistics or subsystems to look at. So I think building up some of those subsystems with what we have been trying to do is population-wide, what Chris

emphasized at the beginning. So even with some of the mental health statistics that NCQA gathers on control and follow up, it's only for the plans that report to NCQA, so it is not even all commercial health plans, it is a subset, and we don't feel that those represent a full state, so work at the state level and national level to start building those up I think is critical.

ED HOWARD, JD: Mary, you wanted to say something?

MARY WAKEFIELD: I just wanted to comment on that as well because it feeds right into I think some of the comments I was making about this need to really push and drill down on system that is - system that is as a term sounds pretty abstract, but you just put a finer point on it, and that is to says sometimes we have got systems that aren't talking with each other and yet it is the same patient that is moving among and between them, making so that even if the patient is an individual consumer who is receiving care in one location and then mental or behavioral health care there, and two blocks away receiving care for other health care problems, in some circumstances those two locations may as well be 2,000 miles away because they are not communicating.

What a disservice that is to patients, to consumers and to their families, when that is the best in some circumstances that we can do. So that need to align those services is really critically important, and there is a role

for everybody in trying to focus on system-ness. Abstract sounding, but plays out daily when people access health care at different along the continuum.

MARY GILBERTI: That is a good point.

CATHY SCHOEN: I want to add that - ask the person who sent in the question about the data. In the report on - starting on page 69, for every indicator we tell people exactly where it came from. Some of it is from surveys of patients but some of it is from hospital clinical records from vital statistic records. A lot is, we have benefited from Art pulling these together for us so it is pretty well documented and if there are any questions that you didn't understand the exact source, I would be glad to talk to people later.

ED HOWARD, JD: Thank you, Cathy. Yes, sir.

RYAN ROSS [misspelled?]: Hi, my name is Ryan Ross. I'm with Jefferson Government Relations, and my question has to do - it is a little more general. You know, the panel up here it seems today to be talking a lot about, you know, how we need to increase you know, access to the system. In fact, you know, just in the report it says universal coverage. You talk about information systems. There is a lot of different reforms here. The problem is if you look at current spending in Medicare, Medicaid, you know, and then you are talking about a lot of it, the expansion of this, I mean, it imposes

an incredible financial burden on our government. So how do you address this and how can we, you know, obviously, you know, we can do smaller things which you guys have done an excellent job addressing, but when we look at the big picture here, are we talking about a big tax increase to be able to pay for this?

ED HOWARD, JD: Cathy, you want to start?

CATHY SCHOEN: I'll start. I think it would be nice to start looking at the nation and our national health expenditures are running about 16-percent of our income compared to an average of other countries at eight to 10. And there is a high cost of fragmentation so yes, we all focus on the budget that we are looking at, but looking at globally where we could go, I think it is going to be where we need to go as a country.

Some of the perverse or misaligned incentives that happen even between Medicaid and Medicare on nursing homes are phenomenal and a nursing home that does a very good job on taking care of their residents, keeping them well and healthy won't have an admission to a hospital very often. But the home that doesn't, when that patient is admitted it becomes a Medicare dollar, the home still gets paid to hold the bed. When the patient comes back, they are paid at the Medicare rate rather than the Medicaid rate, so you have got, you have got an incentive for not providing care.

So I think we need to really start talking about a population focus and with that focus we would see a different trajectory on Medicare, Medicaid and private instead of looking at each budget separately. It may take some thinking socially on that we are all investing now and is there a really big difference between a premium dollar and a tax dollar.

ED HOWARD, JD: Anybody else? Yes, Chris.

CHRISTOPHER KOLLER: Primary care, investment in primary care, advanced medical home that is cheap. Primary care is like 10-, 5-, 10-percent of the total premium you increase payments there for an advance medical home by 20-percent, they feel like they hit the lottery and you barely move the needle on the total expenses. HIT in Rhode Island, we could do a health information exchange for $20 million on an annual spend in the state of $6 billion, so that is a small piece.

Insurance expansion, to cover everybody in Rhode Island, to do a Massachusetts, you know, instead of an "Oklachusetts" it would be like "Okla-island" except they would be right across the border from us. We estimate that would be around $50 million a year in state plus the matching federal if you could get the political will. Fifty million, you have been talking to my governor, because that is what he says. We have got to be able to reallocate the money. Fifty

million sounds like a lot. What I remind people is that our favorite team, the Boston Red Sox, paid $50 million for the rights to negotiate with Diasuke Matsuzaka and that didn't even get them in the door. That just got them - that went to Scott Boras, the agent. So it is about priorities.

PETER BUDETTI: Also like to address that question. I think that in addition to the tremendous savings that would inevitably flow from addressing what Cathy talked about, the transaction costs in our current fragmented system are just horrendous. But I think the other point to make is that where our costs are going.

A lot of our expenditures are going to care for chronic conditions, many of which could be ameliorated or prevented if we had more of a population-base approach. We have a major employer in Tulsa who, a couple of years ago, implemented a new very energetic shall we say - bad choice of words - wellness program, fitness program for employees, and without any changes whatsoever in the health plan, experienced to his great surprise and satisfaction, experienced a zero rise in health care expenditures the following year. And the feedback was immediate, by focusing on weight, focusing on tobacco, and focusing on activity and getting people to do personal health assessments and responding to them, he is - his premiums were flat for the following year.

So I think there is a lot, so there are two huge areas that I think we could have savings that we could look to the transaction costs and the prevention.

MARY WAKEFIELD: If I could just say, if you look at the state scorecard you can start - you can look at some of the states that are doing fairly well in terms of for example expenditures per Medicare beneficiaries. So I think that is one of the values of the score card. It helps you focus your attention on places that are functioning fairly efficiently without compromising care quality. And that's, that's pretty important, so it isn't, it isn't all as my colleagues have said about spending more money, it is about allocating resources in a smarter way to achieve really good solid outcomes and there are some examples of that in the scorecard.

ED HOWARD, JD: Yes. Carl?

CARL POLZER [misspelled?]: Thanks. This is Carl Polzer. I'm with the American Health Care Association and the National Center for Assisted Living. It is a mouthful. I just wanted to ask a question of Cathy on the scorecard about how the senior population plays into the access measure. And I wondered is there less variation, because I'm assuming the access measure includes an uninsured rate. Since the seniors don't really have one because of Medicare, would there be less variation in the senior population and if it were taken

out of the overall measure for that reason, would there be more variation among the states? I don't know how you calculated that. Would that, you know, sort of ballast out of the calculation?

CATHY SCHOEN: I understand the question. On the access measures we had insurance rates for the under 65 and insurance rates for children. So we did not factor in the fact that an insurance rate if we did the whole state, if you had more elderly would look better or worse because they have Medicare. When you look at the Medicare population, and there are some statistics in our report but we did not try to subdivide the population, if you look at things like ambulatory sensitive conditions for the elderly, and ARC has done some work on this, the range of variations across states is much narrower for that insured group.

There is still variation and one could drill down and say, where is that coming from? We get phenomenal variations when you look at the under 65 and you can do it community by community. Peter could probably tell us which communities he would know exactly where there would be really high rates. So that basic access barrier, lack of primary care, lack of hypertension under control, diabetics who are not able to continue on with insulin, shows up particularly in under 65.

But, for the people on Medicare, in the room, we're starting to see that that means when that population comes

onto Medicare, they are coming in sicker. You know, so there is a delayed cost that is directly on the federal budget especially for that 50- to 64-year-old group.

CARL POLZER: Thank you.

ED HOWARD, JD: I've got a question for Chris Keller, or Chris Koller, whoever wants to answer it. You seem to imply, the questioner writes, the competition among providers presumably is not always a good thing. Could you please elaborate on this?

CHRISTOPHER KOLLER: How - my remark about competition was particularly with regard to health insurers in a small group market, where un - if you have unregulated competition in a small group market, you have a race for healthy people and a race away from sicker people, because that is how you make money in health insurance, is you find the healthy people and avoid the sick people. I think for among providers, what we want as a matter of public policy, is competition based on quality and service, not so much - we don't think particularly because of the risk adjustment, the conversation we had earlier, competition based on price ends up just being trying to find the healthy people.

We think that - and actually, you know, I'll say as a running a Medicaid health plan, there are three HMOs in Medicaid managed care who are all given the same price and then we compete for the love and affection of our enrollees

based on service and quality. That's a very different equation and it is a very different competitive dynamic than if we are competing based on our ability to find the healthy ones and exclude the sick ones.

So if you can have good standard metrics, and actually that is what the Commonwealth Fund is doing here is they are trying to create a little bit of healthy competition among the states based on some measures. And that's not - that's how quality measures work. When we do hospital-based quality measures it doesn't help the consumers choose. They are not going to pick a hospital based on that, but the hospitals watch it and they try to improve what they are being measured on.

ED HOWARD, JD: Okay. The same person has a question for all of the panelists. Can we significantly improve in quality and access without first addressing the issue of poverty across states, since it is so intimately linked? Peter?

PETER BUDETTI: I made a point of noting the important reciprocal relationship between the economic status and the health status of a population, and it is a reciprocal relationship. So I don't think though that we can say that we can simply, what, pass out money and make people wealthier and then they'll be healthier. But you need a healthy population to have a strong economy and you need to have a

strong economy to have a healthy population, so they really feed into each other. And I think that is really the way you know, that I have always approached that question.

ED HOWARD, JD: Anybody else? Mary?

MARY WAKEFIELD: I disagree. The - what we are focusing on here is largely what goes on inside the bricks and mortar of health care delivery systems and yet I think most of us in this room would certainly acknowledge that what goes on outside of our health care delivery systems also is extremely influential in terms of the health of individuals in populations.

The commission is focusing primarily on what goes on inside the health care delivery system but we are not immune to that you know, we are not viewing this as purely sterile and separate and apart from what goes on outside of the system. They certainly interact, but a lot of what we are focusing on are the enormous challenges inside the system.

CATHY SCHOEN: Just to underscore what Peter said about them flowing in both directions. We have a Medicare program with a two-year waiting period for the disabled and we basically - are driving people into poverty because if you allow their disability to go without treatment, they are not longer able to work. And you get that with diabetes where you keep it under control and you can keep someone working and able bodied. You let it go down and you suddenly have

someone who is no longer able to work and that, that feedback of healthy people able to be productive and productive people able to stay healthy, also has this - when there are points that are critical, helping the person do the right thing to be able to manage their disease is critical and we have a health care system that it is not cheap to do that.

ED HOWARD, JD: We have just about 10 minutes to go and a few more question on cards, and if you want to take one last chance at a microphone, you can get one it. We probably will not get to all the questions on the cards. This one probably is directed at you, Cathy, most immediately anyway. What were the three most significant variables that influenced the state rankings out of those 32?

CATHY SCHOEN: I'm not positive we have a three most. As I said, we have this strong link between accessing quality, so they are moving together. If we pulled those uninsured rates or insurance rates out, the quality metrics on a lot of these would still put the state where they are. We found these were pretty robust. We can remove a few indicators, add a few and the rankings didn't change very much. But if you think of the - that access and quality link as being very strong, those are very important throughout it.

Um, so I don't know who asked the question, but I can talk to you later about it. The avoidable hospital cost metrics are very important but the states that are high on

one of those were high on multiple of them, so there were some cluster movements among some of the indicators. They were not necessarily always high so asthmatic didn't necessarily go with congestive heart failure. So that there is some robustness in this. We would love to have more state-based measures.

ED HOWARD, JD: This question wants to know what patients can do, or potential patients, since this person doesn't like the term "consumer?" What is it that the folks who are receiving the care can do to help promote a high performance health system other than using report cards, like the Commonwealth Fund has produced? Any suggestions? Chris?

CHRISTOPHER KOLLER: I'll take a shot at that. You now the - in spite of what we might think, I don't think the average consumer is going to pour themselves over the Commonwealth Fund's Web site and sort of go through these measures, and it is probably bully for them. It is just left to us to do that, but I think - we think about that from a how do you engage consumers and I would go back to the responsibility of the system, the health system, since we are really talking about that today, to help people realize the importance of a connection with an advance medical home. That really is kind of nucleus of this. And what - the place where we try to start it in Rhode Island are sort of the

intuitive link that we try to help people make is in pediatric care.

It is very easy for families to realize the importance of their kid having a good medical home and a good pediatrician. And that has been one of the lessons in Rite Care. It has been very easy, once you give - this is where income has nothing to do with it, and language has nothing to do with it - once you give them that card, they want to get care for their kids. They want to get the kids in to the pediatrician and/or the family practitioner and have a good healthy relationship start up there.

So how do you expand on that notion? In Rhode Island one of the things we have been looking at is how do you change the nature of health insurance benefits to create an incentive for people to do quote "the good things," to fill out a health risk assessment and share that information, to have a primary care physician, to cooperate with disease and case management programs.

In our case, we have actually put together a small group benefit, a special insurance package that we are having the insurers sell, that offers people lower premiums, so you follow the money, if they do five things, select a primary care physician, fill out a health risk assessment, commit to try to maintain a healthy body weight and to stop smoking and to - or stay nonsmoking, and to cooperate with disease and

case management programs. Those are sort of basic behavioral things that I think would - that we believe contribute greatly to it, and we are working with the health insurers and the employers to promote those sort of smart benefits.

MARY WAKEFIELD: Now that we're calling out the consumer organizations at the state level to be part of that since they are not called patient organizations - I'm going to have to use that term, to engage them as part of the dialogue in consumer organizations moving forward to accept the challenge in their respective states to work with health care providers, state policy makers, et cetera, to try and move the mark on this. I think that is a vehicle for engaging consumers, whether you are talking about your state level AARP or some other state organization. So reaching out to individual consumers, not always there as an audience perhaps for this kind of report, but gosh, the organizations at the state level that represent them and there are all sorts of organizations certainly could be engaged in this agenda.

CHRISTOPHER KOLLER: Let's be clear. The alternative is high deductible health plans. You know, one public policy answer is a $2,500 deductible, good luck and God bless. And at least in Rhode Island, there is a lot of misgivings about that sort of policy. We are afraid of unintended consequences. We are afraid of under-insurance. The

providers are screaming about bad debt and fundamentally we don't think that - or there are concerns that people are different from cars, you know, you buy collision insurance and then it is up to you to take care of your car and if you have to take the bus, that is your problem. We sort of all chafe at that when it comes to health care. We make people wear seatbelts. We make people buy, wear helmets - except in Rhode Island, where we make the passengers wear motorcycle helmets but not the driver. [Laughter] We have not quite figured that one out yet, and so that points to there has got to be an alternative to just a high-deductible health plan.

This, whether it is a public health function, whether it is an education, whether it is a consumer outreach, there has to be some alternative to it.

ED HOWARD, JD: Let me just ask just one question that didn't come in on a card but it was implied in several questions and comments. We have now a baseline of state activity and state ranking. We have a baseline national report that the Commonwealth commission has produced. Is there a plan to update these so that we can mark either the progress or the lack of progress?

CATHY SCHOEN: I like better being asked if there are plans to update than we were asked the other day where they were going to get down to the county level. [laughter] And then town, I guess. We will be updating these regularly. We

plan on updating the national report and releasing it next spring. Part of that is some of the indicators we are using take some time to update and particularly this mortality amenable is for national we benchmarked for other countries as well as in our country and WHO reports from countries on mortality are slow. We will be updating the state report regularly and we may go down to some subpopulations and we haven't quite figured out exactly the schedule. As ARC expands and the federal government expands our capacity to know something at the state level, we hope to be expanding the indicator set as well as the update.

FEMALE SPEAKER: Yeah, I have a question. I think you already answered it actually, Cathy, just now actually, with this last question. But I just want to tap on it just a little bit further. And so when you all are updating these reports, you know, score reports, are you going to look at data this aggregation as far as race and ethnicity is concerned?

CATHY SCHOEN: Yes, and if - I mentioned at the outset that those of you who are interested in more detail that's in the report should get our data tables. We have 11 indicators and all the equity comparisons are in that set of tables. So where we could, and where the population based within a state had enough race and ethnic subgroups, we have

11 indicators where we have gone in and shown what the differences are within the states on those indicators.

Now, we have got some limits on the extent to which we can do that. Some of the hospital clinical quality indicators are reported on an all-hospital level rather than patient base so we could say, in a community with a high percent minority, but we can't do it on a patient level. But we will probably try to expand those, but there were a lot of limits. Some places we could get race ethnicity but we could not get income. And so we have a mix of those, but they are all in the report.

FEMALE SPEAKER: And that is broken down in terms of Asians, Latinos and Native Americans?

CATHY SCHOEN: Again, where we could do it. And you know, we are best able to do that where it is patient-reported survey data. And the state level survey data we have available, if you are in a smaller state with a small percent of the population being in that group, we don't have enough sample size to be able to say anything about subgroups, so we have differential ability to do much more than the big minority groups. And in some states, it is not enough of a population size to go to that level.

FEMALE SPEAKER: Okay, thank you.

ED HOWARD, JD: And that emphasizes a point we have heard several times this afternoon which is data, data, data.

If you can't measure it, you can't change it. And if you don't have the data to measure it, then the underlying premise doesn't work.

So it's a very good stopping point. We will pick this conversation up as we need to. I want to reiterate our thanks to the Commonwealth Fund, particularly the staffs of the commission and the staff of the Alliance for helping put this program together. Thank you for being such a good audience and an attentive audience and one that fills out their evaluation forms as they listen to my rambling comments at the end, and ask you to join me in thanking our panel for an extremely useful contribution to this conversation.

[APPLAUSE]

[END RECORDING]