

AcademyHealth
State Health Research and Policy Interest Group Meeting Summary
June 2, 2007
Meeting Summary

AcademyHealth's State Health Research and Policy Interest Group formed in 2005 to provide a forum for researchers, policymakers, and practitioners to share state-level research that emphasizes the unique challenges of working within a state policy and political environment. The group's third annual meeting was held June 2, 2007 in conjunction with AcademyHealth's Annual Research Meeting in Orlando, Florida. The meeting was sponsored, in part, by The Commonwealth Fund, Georgia Health Policy Center, the Robert Wood Johnson Foundation, Rutgers Center for State Health Policy, State Coverage Initiatives (SCI), and State Health Access and Data Assistance Center (SHADAC).

Through a call for proposals process, the group selected speakers to highlight innovative approaches to address state policy research needs, sound applied policy research methods, and effective strategies for collaborating, communicating, and translating research into policy. The first panel discussed methodological strategies to assess the impact of coverage policies. The second panel focused on health care reforms and the policy process, while the third panel of speakers discussed findings from The Commonwealth Fund's State Scorecard on Health System Performance. (See agenda in binder.) A poster session of relevant topics was also available to Interest Group attendees. (See list and abstracts of posters in binder.)

Session One: Using Various Data Sets and Methodological Strategies to Understand the Impact of Coverage Policies

This session was designed to spotlight research methods and data sources used to evaluate state health policies that have an effect on public coverage programs. The first presentation, by Andrew Bindman, M.D., University of California, San Francisco, used hospital discharge data and administrative data from California's Medicaid program (MediCal) to evaluate the impact of interruptions in Medicaid coverage on the risk of preventable hospitalizations. The second presentation, by Cyril Chang, Ph.D., University of Memphis, used survey data to assess insurance coverage, health status, and utilization among people who were disenrolled from the TennCare program in Tennessee. The third presentation, by Lisa Clemans-Cope, Ph.D., The Urban Institute, used a micro-simulation modeling approach and national databases to inform state policies. Specifically, she evaluated the effect of publicly-funded reinsurance strategies to reduce private health insurance premiums and to increase coverage.

Do Interruptions in Medicaid Coverage Increase the Risk of Preventable Hospitalizations?

According to Bindman, data have shown that more than half of Medicaid enrollees nationwide have had interruptions in coverage. Individuals who have interruptions in Medicaid coverage are less likely to receive primary and preventive services because they often lack insurance to help

pay for these services. Additionally, it has been noted that low-income individuals cycle in and out of Medicaid coverage, and they often cycle back into Medicaid coverage when they require hospitalization, since facilities have a strong incentive to enroll the uninsured into appropriate coverage programs.

Not only is this churning in and out of coverage an issue within Medicaid, re-certification is another component that can create coverage lapses. Federal law requires that individuals reenroll in Medicaid at a minimum of every 12 months. Within the guidelines of federal law, states have discretion to determine policy with regard to re-certification. When states face budgetary pressures, there is often a push to control costs by erecting subtle barriers to enrollment such as making re-certification determination more aggressive. Bindman noted that in 2001 California did the opposite for children in Medicaid—the lock-in period was extended from six months to 12 months.

In the study, Bindman utilized two sets of data. First, he used hospital discharge data from the Office of Statewide Health Planning and Development, which contains diagnostic codes, and the month and date of admission. Those data were then linked to the Medi-Cal Enrollment Database, which includes information on demographics, monthly enrollment history, aid category, whether or not they had fee-for-service or managed care, and if they had access to other insurance. The two data sources were linked primarily through the use of the enrollee's social security number, and also some probabilistic data linking.

In the survival analysis, Bindman evaluated whether or not interruptions in Medicaid coverage affected the probability of an ambulatory care sensitive (ACS) admission for adults and children in Medicaid. ACS admissions are conditions that respond to timely and effective care in the outpatient setting. About 60 percent of the Medicaid population had an interruption in coverage during the five-year time period the study captures. Bindman found that the cumulative probability of having an ACS admission among those with interrupted coverage was substantially higher than individuals with continuous coverage (relative hazard = 3.72, $p < .0001$). Also, he noted that 6 percent of the ACS hospitalizations were previous Medicaid enrollees, but uninsured at the time of admission; approximately 25 percent of these individuals then regained Medicaid coverage on the basis of their ACS admission. Bindman noted that this has an important policy implication as a “hidden cost” of interrupted coverage.

Bindman also evaluated the impact of extending the lock-in period in Medicaid for children from six months to 12 months. He found that the extension in the lock-in period was associated with a lower probability of ACS admission (relative hazard = 0.75, $p < .0001$). In other words, the eligibility extension was associated with a 25 percent drop in ACS admissions.

Bindman's study illustrates a real dilemma for policymakers. Short-term efforts to control costs by raising barriers to entry for public programs like Medicaid may translate into increased costs since individuals with lapses in coverage are statistically more likely to be admitted into the hospital.

What Happened to Those who Lost TennCare?

The TennCare reforms of mid-2005 disenrolled almost 170,000 adults. To analyze the impact of this loss in coverage on this population, Chang and colleagues conducted a survey, focusing on access, utilization, out-of-pocket expenses, satisfaction, and safety net usage. The survey, commissioned by the Bureau of TennCare, was designed in three waves of interviews—one at six months, another at 12 months, and the final interview at 18 months. The data presented at the meeting represent the first wave of interviews.

The study found that 72 percent of disenrollees remained uninsured seven months after disenrollment, while 14.4 percent of disenrollees obtained non-federally funded health coverage. Additionally, Chang found that preventive care utilization decreased significantly for disenrollees as compared to a marginal increase in those continually enrolled in TennCare. Chang also noted that disenrollees experienced increased delays in receiving care. Emergency room and hospitalization use rates decreased significantly for both the disenrollees and those continually enrolled. Health status between disenrollees and continued enrollees did not differ. Disenrollees experienced significantly increased out-of-pocket expenses and increased difficulty affording prescription medication. Chang also noted that both disenrollees and the continually enrolled knew little about the safety net services that are available.

Simulating Publicly Subsidized Reinsurance Strategies in Three States

Reinsurance strategies, or insurance policies for insurance companies, have become a larger part of health reform conversations. Similar to the *Healthy New York* program, the simplest form of structuring a reinsurance program reimburses primary carriers (those with direct contracts with employers or individuals) for a certain percentage of medical costs between a lower and upper limit. Within this band, the primary insurer pays a specific coinsurance rate (e.g., 10 percent) and the reinsurer pays the remainder. Above and below the reinsured expenditure band, the primary insurer pays 100 percent. Therefore, reinsurance acts as a targeted subsidy. The public goals of reinsurance include attracting healthier individuals through lower premiums, reducing the cost of unfavorable selection, and trying to prevent insurers from only insuring healthier risk pools through medical underwriting.

Some states are considering publicly funded reinsurance programs as a strategy to reduce and stabilize private health insurance premiums and expand health insurance coverage, especially among small businesses.

To evaluate the state-level policy implications of reinsurance on health insurance coverage, employer offer rates, health care expenditures, and state program costs, Clemans-Cope and colleagues created a simulation model. Modeling reinsurance at the state level presented some interesting data challenges. The data needed to be population-based, and representative of state health expenditures and coverage, demographics, and employer characteristics. Additionally, the model required an accurate distribution of health expenses in the upper tail of the distribution across risk groups due to the highly skewed nature of health expenditures. State data were problematic due to sample size concerns. Because no databases contain data that capture all of these dimensions, they built their own dataset from multiple sources.

To make the dataset, they used national, population-based data from the Medical Expenditure Panel Survey-Household Component (MEPS-HC). Then, they adjusted the data so they were consistent with National Health Accounts and high-cost claims from actuarial databases. They re-weighted the data to match the state's characteristics as measured by the Current Population Survey, or another state survey. Then, they assigned workers to synthetic employers to match the state's firm size/industry mix, as gathered from the Statistics of U.S. Business (SUSB). Clemans-Cope and colleagues then built up premiums from covered expenses and benchmarked to state premiums, as found in the Medical Expenditure Panel Survey-Insurance Component (MEPS-IC).

Using this dataset, they applied a reinsurance policy. Each policy scenario included different changes in employer-sponsored and non-group (ESI/NG) premiums. Based on the best evidence of responsiveness (elasticity) in the literature, they computed changes in firm offer rates. In other words, this part of the model elucidated which employers changed their offer rates due to the reinsurance program. Then, they modeled changes of take-up due to the decreases in premium costs for people both in employer-sponsored insurance and non-group insurance based on elasticities from the literature. The simulation then recomputed the ESI/NG premiums for the new risk pool based on the differences in firm offer rate and employee take-up.

From this work, they believe that state micro-simulation modeling is feasible based on large national data sources. Moreover, Clemans-Cope and colleagues stressed the importance of simulation analysis in that it allows states to model different options in order to see the tradeoffs involved in choosing different policy parameters (such as eligibility rules, reinsurance thresholds, and coinsurance levels), and the overall impact of publicly subsidized reinsurance on coverage and premium costs.

Evaluating Health Care Reforms and the Policymaking Process

This session was designed to examine various aspects of health care reforms both in terms of the policymaking process and the impact of the reforms on affected populations. The first Presentation by Jill Rissi, R.N., M.P.A., St. Luke's Health Initiatives, focused on expanding an understanding of what constitutes evidence in the policymaking process by exploring the tacit meanings symbolized in the rhetoric, environment, protocol, and documents associated with the health committee of a state legislature in order to identify strategies that promote the use of health services research in making policy decisions. The second presentation by Debra Lipson, M.H.S.A., Mathematica Policy Research, Inc., examined Maine's Dirigo Health reform plan and the sought to measure the impact of the insurance subsidy program after two years of implementation, determine the sustainability the state's financing strategy for DirigoChoice subsidies, and assess the relevance of Maine's health care reform components for other states. The third presentation by Jennifer DeVoe, M.D., D.Phil., Oregon Health and Science University, looked at the 2003 Medicaid reforms in Oregon to find families with children eligible for public health insurance but not enrolled; the primary aim was to identify barriers to enrollment in the Oregon Health Plan (OHP).

Redefining Evidence: Lessons from the Policymaking Process

Jill Rissi addressed a key problem in the policy process: why don't policymakers use evidence and data to make decisions in state health reform efforts? She observed that a lot of money is spent on randomized control trials, and cost benefit and cost effectiveness analysis, and then decisions are made that seem to be somewhat antithetical to the research. She was interested in looking at the tension between research evidence and everyday, on-the-ground experience which seems to rely on the anecdote, the 'n' of one, etc. Her study tried to create a qualitative matrix using ethnography, personal narratives, in-depth conversational interviews, and language and textual analyses. This study utilized three different sources of information: observations from the Committee on Health in the Arizona House of Representatives; interviews with legislators, lobbyists, policy analysts/advisors; and documents (legislative summaries, articles from one journal and two newspapers, and newsletters).

First, the data were keyword coded based on their content, on whose perspective they came from (insider/outsider, identity, authority), and on the issues they addressed. Once transcribed, Rissi utilized NUD-IST software to analyze the data. The software also enabled her to look at the setting, tempo, and the relative position of the information in order to get a better sense of how decisions are made. For example, Rissi recalled a situation where two women—one a powerful member of the health committee, the other a friend—had a conversation about the friend's diagnosis with malignant melanoma. That same year, the legislature passed a skin cancer screening bill. Rissi noted that there were no research data used to support the enactment of the bill—it was two close friends talking informally.

Rissi's primary finding was that it is not about the data. Sometimes, it's not even about the issue. She noted that statistics used in hearings are not cited and, more importantly, that policymakers can find data to support any issue. Often, values are masqueraded as data and decisions are made on a quid-pro-quo arrangement or based on relationships.

Her findings also indicated that, on the surface, it is sometimes difficult for those outside the direct political process to know how decisions are being made. Researchers, she noted, have reasonable entrée into the legislature—they are not part of the inner circle, but also not outsiders. According to Rissi, researcher status is both a blessing and a curse—researchers generally know what is going on, but there are other aspects of the process that are somewhat lost to researchers.

Rissi posits that policymaking is always about relationships. Legislators, in general, do not trust data. Sometimes, they do not even trust data coming from their own legislative staff. Unfortunately, Rissi noted, the legislative staff in the Arizona House work for the Speaker, they do not work for the legislature as a whole. The data presented by the legislative staff are not always known to be unbiased—the state legislative staff tends to be more partisan than the Congressional Research Service, which tends to be more balanced. On the other hand, Rissi noted that people trust the message if they trust the messenger.

Rissi noted that tacit knowledge is requisite and her research indicates that the implications of insider/outsider status are important to understand in the context of the role of the researcher.

Finally, time and place define the process. Rissi said that researchers are objective, have reasonable entrée, and are viewed as credible. Data do not speak for themselves. What legislators want to know from researchers are the qualitative aspects of data. The more compelling the context, the more the legislators will be willing to look at the research.

Using a Mixed Methods Evaluation to Assess Health Care Reform in Progress (The Maine Experience)

In her study, Debra Lipson wanted to translate Maine's experience in health care reform to policymakers in other states. When Dirigo Health passed in 2003, Maine was considered a leader—the first in over a dozen years to aim for universal coverage. It did so in a way that connected its expansion efforts with the other critical goals of cost containment and quality improvement. In this study, Lipson wanted to understand the relevance of Maine's universal coverage goal—is Maine leading the way because it is the first, in a while, to attempt universal coverage; is Maine leading the way for other states, or are people putting too much emphasis on Maine's Dirigo Health?

Using a mixed methods study design, Lipson evaluated a few key aspects of the Dirigo Health reform effort. The study design utilized a variety of qualitative and quantitative data including administrative data from Maine's new product DirigoChoice, a small businesses survey, stakeholder interviews, and a systematic comparison of Maine to other states.

DirigoChoice enrollment has grown to about 13,000 to date—very good for a new program, but was not as strong as advertised by Maine state officials. The net enrollment of small firms slowly tapered off as the program continued, suggesting that it was not as popular as the state had hoped. Another question Lipson evaluated was whether or not DirigoChoice was enrolling previously uninsured individuals. Lipson found that only 31 percent of those enrolled in DirigoChoice were previously uninsured; 65 percent of people enrolled in DirigoChoice had prior coverage.

According to results from the small employer survey, those employers who offered DirigoChoice were much more likely to have low-income workers and have very few employees, as compared to firms who offer other health coverage options. Firms that considered DirigoChoice, but did not enroll, had several reasons: the coverage was too costly, or unaffordable; the benefits offered did not fit employees' needs; and they did not qualify.

According to Lipson's evaluation of stakeholder opinions, there are some points of consensus for both the strengths and weaknesses of DirigoChoice. First, Lipson found that many stakeholders agree that the benefits are more comprehensive than most small group and individual policies in the market, and the subsidies for premiums and deductibles made the product affordable for low-income individuals. Stakeholders also agreed that some of DirigoChoice's weaknesses included the fact that small firm enrollment was depressed by high premiums, that 60 percent employer contribution was a requirement, that incentives were weak and administrative burdens high, and marketing was problematic.

Maine officials expected part of Dirigo's financing to come from a Savings Offset Payment (SOP). The SOP attempts to capture savings from reductions in uncompensated care and transfer those savings into premium subsidies. However, the legal challenges and controversy surrounding the SOP took away from Maine's overall goal of coverage, and forced Maine to consider other funding alternatives to SOP.

As for lessons learned, Maine's experience has been important. Lipson believes that other states enacting reform legislation will encounter implementation issues because it is very difficult to design a benefits package that is comprehensive and still affordable. Additionally, Lipson believes that financing the expanded coverage by attempting to shift institutional subsidies into premium subsidies is another difficulty that other states may also have to face.

Finding Uninsured but Eligible Children in Oregon After Medicaid Reforms

Jennifer DeVoe evaluated the impact of the 2003 Medicaid reforms on children in Oregon. The Medicaid reforms split the Oregon Health Plan (OHP) into two different groups: 1) OHP Plus, which had similar benefits to the original OHP, no premiums, no co-pays, and enrolled all eligible children and categorically eligible adults; and 2) OHP Standard, which had a leaner benefit package, stricter rules, premiums, co-pays, and enrolled low-income adults who do not qualify for OHP Plus.

Although the reform was targeted at adults (and was not supposed to affect children), DeVoe's study measured the impact of the Oregon reforms on children. To do this, DeVoe and colleagues conducted a survey of Oregon's food stamp families to find out why many eligible children lack insurance coverage and to identify factors that impacted their access to health care services. They hypothesized that the recent loss of Medicaid status for many adults may have impacted children's access to health insurance coverage.

DeVoe and colleagues conducted a random sample of all families with children ages 1-18 enrolled in the food stamp program. They found that nearly 11 percent of the children in this population, who were presumed eligible for the Oregon Health Plan, were uninsured. Higher rates of uninsurance were associated with being: Hispanic, older than fourteen years of age, living in a household earning between 133 to 185 percent of the federal poverty level (FPL), having an employed parent, having an uninsured parent, and having an adult in the household who recently lost OHP coverage. Over 26 percent of the children had a health insurance coverage gap in the 12 months prior to the survey.

DeVoe's research came at an opportune time—the policymakers at Oregon Health Research and Evaluation Collaborative (OHREC) discussed the fact that children's coverage may be politically a more feasible target. Around the time of the governor's reelection campaign, the governor made a pledge to cover all kids in Oregon. Called the Healthy Kids program, the governor charged the Medicaid Advisory Committee with setting up hearings and statewide public meetings, and with developing a recommendation proposal.

The recommended proposal expanded eligibility, extended the re-certification window from six months to 12 months, decreased the waiting period to 60 days, simplified enrollment, and provided aggressive outreach to uninsured kids.

To fund the program, Oregon proposed a tobacco tax increase, which was not universally accepted. DeVoe noted that citizenship concerns, opposition to government social programs, the perception that children have access to the safety net, and partisan politics ultimately derailed the Healthy Kids proposal in April. Most likely, Healthy Kids will be proposed as a referendum to Oregon voters.

Instead of seeing the linear continuum of translating research into policy, DeVoe believes that the process is more cyclical—conducting research and evaluation, developing policy-relevant questions, doing exploratory research, composing policy proposals, political debate, implementing revised policy, and then moving back to conducting more research and evaluation.

Poster Session

Posters were solicited from state-based and academic researchers to present findings on their work related to state-level research and policy. Fifteen posters were selected for display. Posters covered a wide range of topics including research on performance-based contracting, health care reforms in Massachusetts and Vermont, as well as new models to expand coverage in the small group markets in Arkansas and West Virginia.

Session 3: The Commonwealth Fund’s State Scorecard on Health System Performance

Conducted by the Commonwealth Fund Commission on a High Performance Health System, *Aiming Higher: Results from a State Scorecard on Health System Performance* is the first state scorecard to look at the health care system, and all the major dimensions of its performance, including access, quality, equity, healthy lives, and cost.

Overview of the Scorecard

Coauthor Joel Cantor, Sc.D., Rutgers Center for State Health Policy, discussed the structure, methods, and findings of the state scorecard. Cantor stated the purpose of the state scorecard is to stimulate discussion among policymakers and others who may have influence in improving the health care system. Also, Cantor hoped the scorecard will stimulate collaboration and action at the state and national level in both the public and private sectors. To do this, the scorecard ranks the states, and also highlights the features of the top-performing states as potential benchmarks for improvement. States are ranked on five dimensions: access, quality, avoidable hospital use and costs, equity, and healthy lives.

The key findings of the state scorecard show that there is wide variation among states; there is a large potential for improvement in both high and low performing states. Cantor noted that the leading states consistently out-perform lagging states, which suggests policies and systems are linked to better performance. Although there are regional patterns, there are also exceptions to these patterns, which make it unlikely that these variations are due solely to demographic and

economic causes. Although access and quality of care reflected two different dimensions, Cantor and colleagues found these measures to be highly correlated across states. Even some of the best states do poorly on some measures, pointing to the significant opportunities to address and improve cost, quality, and access to care. Not one state ranks at the top of every indicator; for some indicators, even the best states are not performing at the top level.

Access is evaluated based on four measures: coverage for kids; coverage for adults; forgone care; and an ambulatory care visit-based measure. States in the Northeast do well; those in the South not as well. Looking at trend data, the percentage of uninsured adults is increasing—from 1999 to 2000, only four states had uninsurance rates of 23 percent or more, compared with 12 states in 2004 to 2005. However, the reverse is true for children—from 1999 to 2000, 10 states had uninsurance rates above 16 percent or more for children, compared to only three states in 2004 to 2005. The difference between children and adult coverage is mainly due to the success of the State Children’s Health Insurance Program (SCHIP).

Quality of care had the broadest range of indicators (14 in total), which fall into three main categories: getting the right care; getting coordinated care; and patient-centered care. Quality of care and access to care are highly correlated. One of the indicators was “adults age 50+ who received recommended preventive care.” In the best-performing state, 50 percent of this population received recommended preventive care while, in the worst state, only 33 percent of that population received recommended preventive care—illustrating the great need for overall improvement in quality across all states.

Avoidable hospital use and cost has nine different measures—seven measures of avoidable hospital use and two cost measures. Here, the West is doing much better, and the Northeast not as well, compared to the coverage and quality dimensions.

For the healthy lives dimension, Cantor stressed that many factors determine the health status of a population, one of which is health system performance. Migration, population demographics, and incidence of disease may not be a function of how well the health system performance operates, but all can impact the healthy lives indicators. However, Cantor said the study chose indicators that would be most responsive to health system performance. Unlike other dimensions, the South and the West performed well in the area of healthy lives.

The way equity is measured in the scorecard is to measure the gap between the most vulnerable group and the national average, with vulnerable populations being defined as low-income, uninsured, racial and ethnic minority. They also compared the state’s most advantaged group to most disadvantaged group. In the states with the biggest gaps between the most advantaged group and most disadvantaged group, the advantaged group often had worse rates than the national average, with the disadvantaged group being ranked far below the national average.

According to the state scorecard, if all states achieved top state performance, 22 million additional adults and children would be insured and nine million additional adults (50+) as well as four million diabetics would receive recommended care. There would be \$22 billion annual Medicare savings if high cost states came down to average, and there would be more than one

million fewer Medicare hospital admissions and readmissions per year (savings of \$5 billion+ per year) and 90,000 fewer premature deaths.

Cantor stressed that the state scorecard has data limitations. The scorecard relies mostly on Medicare and hospital admission data because they were available. The scorecard does not include measures of overuse and waste, or measures of the potential to improve, and has equity data gaps. Another limitation is that the researchers have chosen the state as the unit of measurement. This masks the variability of state performance between different geographic areas within a state.

Cantor concluded that the health care system as a whole needs better measures in order to improve. The scorecard is an important first step and it calls for state and national leadership, public and private sector involvement, and collaborative strategies to direct the entire system toward improvement.

Response from Alan Weil, National Academy for State Health Policy

Alan Weil, J.D., M.P.P., congratulated the authors and The Commonwealth Fund for creating an extremely well- and carefully-done report. According to Weil, any report that ranks states can get a headline, but the question is: can they get anything more than that? Weil stressed that this represents a particular challenge when determining how to make best use of this report.

Weil formulated his response around three basic points:

First: the report can serve as a basis of discussion at the state level, which Weil believes is the report's most promising use. According to Weil, this report is a powerful tool. By breaking down the question of what does it mean to be "high-performing" into components and rankings, states can more easily discuss their goals (e.g., they want to be the best state, they want to be like state X, they want to perform better). By breaking it down into dimensions and rankings, states can have a sense of what it would mean to improve, which is critical for moving the discussion forward.

Second: the report can serve as a basis of discussion at the national level, although Weil is not optimistic that will happen, despite its importance. Weil thinks the question revolves around how you frame state variability and characterize it so that it yields a productive national discussion.

Third: the report can serve as a basis for further research. Weil stressed that we must be cautious of the scorecard's use of domains. The scatterplot showing the correlation between access and quality to Weil shows the correlation between access and access—in other words, those domains are measuring different components of access. As researchers, Weil said we have to be careful when bundling measures together into access and quality, that we know what is contained within those composite domains.

Weil also said there was great potential in thinking about subgroups. He was glad to see the equity ranking, but Weil hoped that research will go beyond state-level analysis into urban/rural, provider type, etc., in order to get more detailed data on equity. From a policy and political

perspective, Weil thought it was interesting that in states where the equity gap was largest, both the advantaged and disadvantaged groups were not performing well—saying that problems with equity affect everyone, and not just the disadvantaged group. He believed this distinction will be important in further discussions.

According to Weil, the primary contribution of this report is its ability to break down broad, complex issues that are lumped together—access, quality, cost, health systems, efficiencies, etc.—into domains and data elements that have research and action possibilities and that can be discussed in concrete terms. He believes it is a good starting point for the research, discussions, and actions that need to occur.

Response from Joseph Thompson, the Director of the Arkansas Center for Health Improvement and the Surgeon General, State of Arkansas

Joseph Thompson, M.D., M.P.H., believes that states are discussing the issues highlighted in the scorecard; however the extent to which reform is actually happening differs among states. However, Thompson believes that the scorecard will help in state discussions by providing comparisons. Thompson noted that he believes the scorecard can provide external pressure to support internal change.

Thompson stressed that health and health care happen at the local level. In Arkansas, providers control decisions—the state does not have large employers, empowered consumers, or active government that are calling for this information. According to Thompson, the scorecard will help push discussion.

Federal agencies and purchasers are now pushing for information on cost, quality, and access to be more publicly available. At the state level, the tension between provider autonomy and provider responsibility will be an important issue when collecting data. Whether or not the data will be utilized for quality improvement, or for accountability, must be discussed.

As Arkansas moves into the summer months, Thompson is hopeful that the scorecard, as with other reports, will help break the logjam and inertia surrounding health care reform in his state. The scorecard, he noted, with its breadth and its depth, will be a critically important contributor to advance discussions that are already underway, and to provide some push for efforts that have been languishing or have been obstructed.