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Issue Brief

Lessons from High- and Low-Performing States for Raising Overall Health System Performance

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ABSTRACT: The authors of this brief interviewed stakeholders in states with high-ranking and low-ranking health system performance, according to The Commonwealth Fund's *State Scorecard on Health System Performance*. Findings suggest there are market, political, and cultural characteristics that can help or hinder health system improvement. High-performing states are more likely to have: a history of continuous reform and government leadership; a culture of collaboration among stakeholders; transparency of price and quality information; and a congruent set of policies that focus on system improvement. Regardless of starting point, state policymakers and proponents for health system improvement can work to align incentives to change provider, health plan, purchaser, and consumer behavior; frame health in terms of economic development to gain public and political support; engage purchasers and payers to drive value and quality improvement; bring stakeholders together to develop goals and build trust; and take advantage of federal funding, incentives, and reform opportunities.

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OVERVIEW

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

Building on the *State Scorecard*, this issue brief identifies factors that either contribute to high performance or—when lacking—create barriers to improvement. Several themes emerged from interviews (see Methods box) with stakeholders in high- and low-performing states:

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1. Socioeconomic and demographic factors are important and, to a large extent, determine a state's starting point for system improvement.

2. There are a number of common themes and priorities for health system improvement in high-performing states that are either low priorities or totally lacking in low-performing states, including:
   - a long history of continuous reform and government leadership on health care issues;
   - a culture of collaboration among stakeholders;
   - transparency of price and quality information; and
   - a congruent set of policies that focus on system improvement.

3. Regardless of a state's starting point or current focus on health system performance, there are promising strategies and lessons that are available to all states that want to improve. State policymakers and proponents for health system improvement can work to:
   - align incentives and goals to change provider, health plan, purchaser, and consumer behavior;
   - frame health in terms of economic development to gain public and political support;
   - engage purchasers and payers to drive value and quality improvement;
   - bring stakeholders together to develop common and realistic goals, and begin to build trust; and
   - take advantage of federal funding, incentives, and reform opportunities.

The findings from this issue brief and the *State Scorecard* show that all states can aim higher. With rising costs putting pressure on families and businesses alike, and new demands and opportunities related to federal reform on the horizon, it is urgent that states take action to enhance value in the health care system. Improving the performance of all states to the levels achieved by the best states could save thousands of lives, improve access and quality of life for millions of people, and reduce costs. In turn, this would make more funds available to pay for improved care and expanded insurance coverage, creating a net gain in value overall.

FACING REALITY: SOCIOECONOMIC AND MARKETPLACE INDICATORS THAT CORRELATE TO PERFORMANCE

The Commonwealth Fund's 2009 *State Scorecard on Health System Performance* identified wide variation across states in numerous indicators related to access, prevention and treatment, quality, avoidable hospital use and costs, and healthy lives.[1] Among the 10 highest-ranked and 10 lowest-ranked states in the

METHODS

Findings are based on analysis of state-specific data comparing 10 highest-ranked states and 10 lowest-ranked states, as measured by overall health system performance on the 2009 *State Scorecard*, and interviews conducted by Health Management Associates with health policy experts and select stakeholders in seven of the high-ranked states and five low-ranked states. We conducted interviews with representatives from a variety of organizations including state health policy centers/institutes, Medicaid agencies, health care commissions and collaboratives, state health foundations, quality improvement organizations, hospital associations, advocacy organizations, and health plans. Detailed findings from seven high-performing states (Delaware, Hawaii, Iowa, Massachusetts, Minnesota, Vermont, and Wisconsin) were previously published by The Commonwealth Fund.[2] Health Management Associates conducted confidential interviews with experts in five low-performing states with the understanding that common themes but not state-specific information would be included in this brief.

Exhibit 1. Ten Highest-Ranked and Lowest-Ranked States (in alphabetical order)

Highest-Ranked States	Lowest-Ranked States
Connecticut	Arkansas
Hawaii	Florida
Iowa	Illinois
Maine	Kentucky
Massachusetts	Louisiana
Minnesota	Mississippi
New Hampshire	Nevada
North Dakota	New Mexico
Vermont	Oklahoma
Wisconsin	Texas

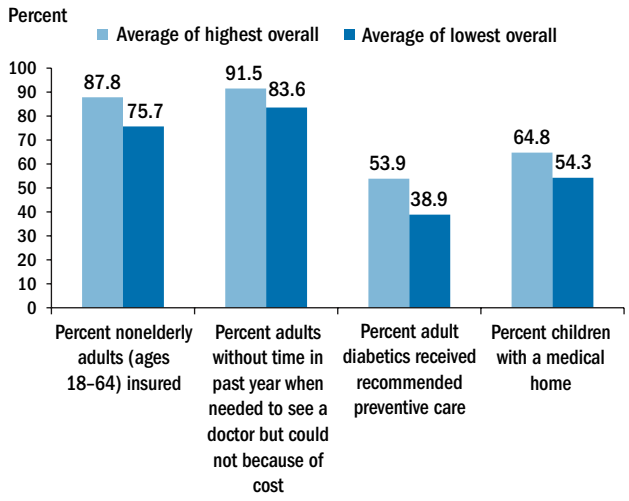
Source: Commonwealth Fund State Scorecard on Health System Performance, 2009.

Scorecard (Exhibit 1), there are particularly dramatic instances of variation. For example, 54 percent of adult diabetics received recommended preventive care across the 10 highest states, compared with 39 percent of adults across the 10 lowest states (Exhibit 2). The 10 lowest-ranked states have higher rates of adult smoking, child obesity, emergency room visits among adult asthmatics, and hospital admissions among long-stay nursing home residents (Exhibit 3).

There are socioeconomic, demographic, and other factors that appear to be highly correlated to health system performance. These factors, to a large extent, can determine a state's starting point for system improvement. For instance, poverty, as expected, is highly correlated to health system performance, because of its relationships with education levels, nutrition, health status, reliance on public programs, state tax base and availability of resources, and numerous other factors. The 10 highest-ranked states have an average poverty rate of 14 percent, compared with nearly 22 percent for the 10 lowest-ranked states and the national poverty rate of 20 percent (Exhibit 4). Median income is 25 percent higher in the 10 highest-ranked states than the 10 lowest-ranked (Exhibit 5). The appendix tables show additional performance indicators, socioeconomic, demographic, health, delivery system, and other characteristics of the top-and bottom-performing states.

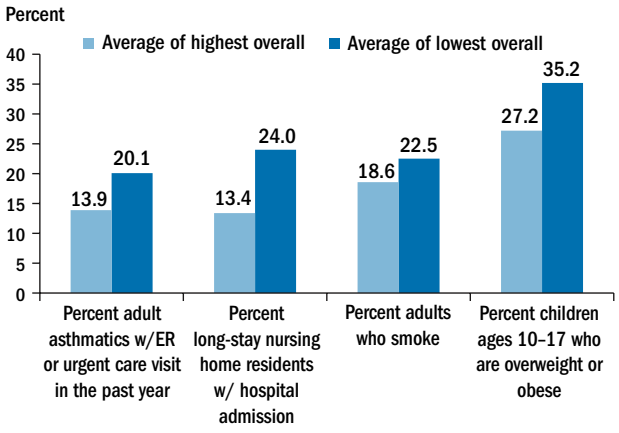
The lower-performing states are challenged not only by higher poverty rates but also by poorer overall health outcomes and higher uninsurance rates that reflect historic patterns of low employment-based health benefits. There are large performance

Exhibit 2. Access and Prevention Measures: How the Ten Highest- and Lowest-Ranked States Overall Compare



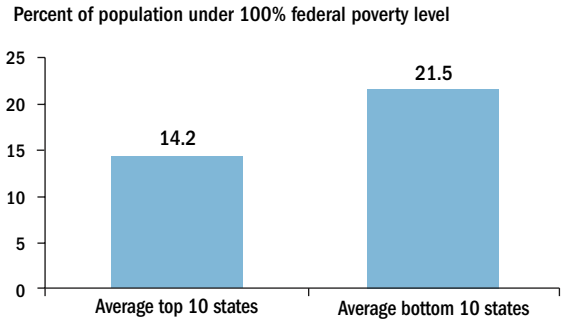
Source: Commonwealth Fund State Scorecard on Health System Performance, 2009.

Exhibit 3. Avoidable Hospital Use and Cost and Healthy Lives Measures: How the Ten Highest- and Lowest-Ranked States Overall Compare



Source: Commonwealth Fund State Scorecard on Health System Performance, 2009.

Exhibit 4. Poverty Rates: How the Ten Highest- and Lowest-Ranked States Overall Compare

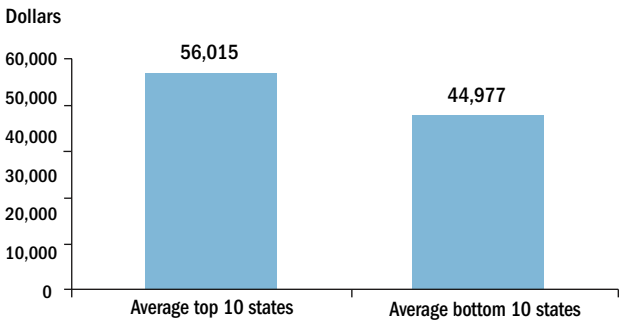


Source: www.statehealthfacts.org.

gaps between these states and their higher-performing counterparts. Over time, seeing low rankings and poor performance on socioeconomic indicators can lead to a defeatist attitude. Several interviewees in these states described a sense of helplessness and a "why bother trying?" attitude, rather than a feeling of "let's roll up our sleeves and see what we can do."

Many interviewee stakeholders in low-performing states reported they commonly hear excuses to justify low performance. Socioeconomic conditions such as high poverty or uninsurance rates are used as reasons for poor system performance. These factors are obviously related to system performance, but when oversimplified can become institutionalized viewpoints that distract from serious examination of the structural, cultural, and other causes of poor performance. "We need to be careful not to create scapegoats," said one policy expert referring to her state's large immigrant

Exhibit 5. Median Income: How the Ten Highest- and Lowest-Ranked States Overall Compare



Source: U.S. Census Bureau, Current Population Survey ASEC Supplements.

> The prevailing attitude in low-performing states is, "why bother trying?" rather than, "Let's roll up our sleeves and see what we can do."
>
> *Health foundation leader in low-ranked state*

population. "We need to take responsibility to make sure the health system performs well for everyone, not blame a few for how it performs."

Diversity in demographics, population, and culture, as well as a strong urban–rural divide were frequently cited as barriers in the low-performing states. These factors can make it challenging to develop statewide strategies and solutions. Counties often have a great deal of autonomy in health care with minimal state oversight, and the safety net is frequently a local responsibility. Further, rural areas throughout the country face challenges securing access to primary care and specialty physicians, achieving economies of scale, and creating integrated delivery systems. In these areas, concepts like transparency and coverage expansion—normal objectives in other settings—are simply not possible with the current infrastructure. Yet a large rural population does not necessarily create barriers that cannot be overcome. The 10 highest-ranked states have, on average, a larger portion of residents living in nonmetropolitan areas (34 percent) than do the 10 lowest-ranked states (26 percent).[3]

Finally, characteristics of a state's health care marketplace may be associated with system performance. For example, in three of the 10 highest-ranked states, 100 percent of community hospitals are nonprofit or owned by state or local government. The average across the top 10 states is 96 percent, compared with a 68 percent average across the 10 lowest-ranked states. The 10 high-performing states also have a higher average, compared with the lowest-ranked states, on the following factors: portion of certified nursing facitlities that are nonprofit or owned by state/local government, portion of community hospitals in highly integrated systems, and HMO penetration rates (Exhibit 6). One might speculate that integrated systems and managed care foster higher performance;

> We need to be careful not to create scapegoats.... We need to take responsibility to make sure the health system performs well for everyone, not blame a few for how it performs.
>
> *Health policy analyst in low-ranked state*

there is literature and ongoing research focused on these questions. While it is not yet clear whether or to what degree these indicators have any causal relationship with health system performance, states might improve performance by examining high-performance marketplace conditions and supporting policies that would help promote such an environment.

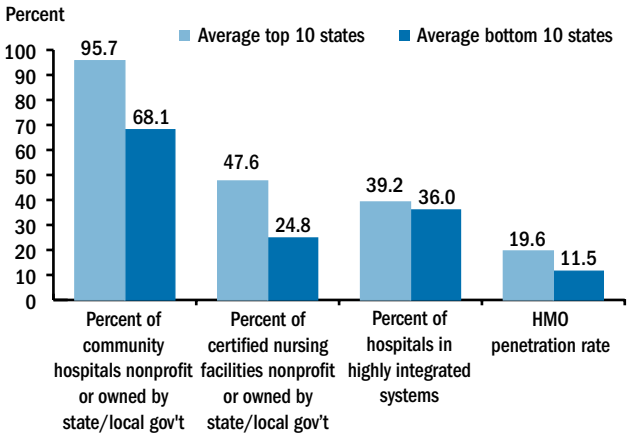
COMMON THEMES: WHAT HIGH PERFORMERS HAVE THAT LOW PERFORMERS LACK

There is no one factor that easily explains overall health system performance in any of the states examined. Rather, there are numerous factors that, in combination, appear to contribute to performance; many are related or build on each other. Often, the factors that high performers view as essential to system performance are simply not in place or not a priority among low performers.

A history of proactive state government and leadership

Each of the seven high-performing states profiled in this brief has a long history of health system improvement that has focused on expanding health insurance coverage for uninsured residents. Most experts in these states credit health reforms enacted in the early 1990s for setting the stage for recent coverage expansions and quality gains. All seven profiled states, for example, made significant, early gains in coverage by extending Medicaid benefits to otherwise uninsured residents. The authority for these expansions was granted by the federal government through Medicaid 1115 demonstration waivers and, in most cases, included significant federal financial support. In all of the high-performing states, state government played an active role convening stakeholders, designing policy solutions, enacting and implementing reforms, and organizing to sustain and build on reforms over time.

Exhibit 6. Health Care Market Measures: How the Ten Highest- and Lowest-Ranked States Overall Compare



Sources: www.statehealthfacts.org, American Medical Association, Aventis Managed Care Digest Series (Hospital/System Digest, 2009); American Medical Association.

In contrast, there is a prevailing sentiment in most of the low-performing states that health care is not a major priority or an appropriate role for state government. Higher priorities in these states include minimizing taxes and promoting local- or county-level responsibility. Policymakers tend to view Medicaid as a drain on the state budget, and many still view Medicaid as a welfare program. Medicaid eligibility levels and benefit packages for adults are very low. For example, none of the 10 lowest-performing states cover childless adults, and income eligibility for parents in nine of the 10 lowest-performing states is set lower than 90 percent of the federal poverty level.[4] In addition, access is often a problem in low-performing states because Medicaid provider rates are extremely low. In eight of the 10 lowest-performing states, Medicaid spending per capita is below the national average of $5,163.[5]

Health disparities in low-performing states are frequently viewed as racial and ethnic issues, tied to stereotypes that dampen enthusiasm for public health investment. When these states consider changes to Medicaid and other health programs, it is primarily for cost containment reasons rather than for providing quality health care to a population in need.

High performers invest more per capita in public programs than do low performers. For example, seven of the 10 highest-ranking states spend more per Medicaid enrollee than the national average. In low-performing states, relatively small public program budgets translate into limited adult eligibility levels, benefit packages, and reimbursement rates to providers. This, consequently, negatively affects access, methods of practice, and trust between providers and state government. Lack of investment among low performers appears to be driven largely by higher poverty rates, which results in a lower per capita revenue base, but is also exacerbated by strong priorities to maintain low taxes. System performance is driven by difficult fiscal realities, but also by the state's culture and political choices. These states have low or no state income, property, or corporate taxes, and no political will to raise revenue for health care.

Health system improvement does not happen all at once, but can take years—sometimes decades—with one layer of success building on another. In high-performing states, it is fairly easy to identify the personalities and organizations responsible for pushing constructive reforms forward. The champions of health system improvement were more difficult for interviewees to identify in low-performing states. In some states, interviewees attributed the lack of state leadership to the design of state government (e.g., a weak executive authority), lack of state control over a strong county-administered system of services, or a culture of scandal that continuously displaces health policy planning and other priorities. The medical and hospital associations in low-performing states were described by interviewees as reactive rather than proactive and not inclined to push their members to collaborate to find common ground for overall health system improvement.

Without this kind of leadership, it is not surprising that there is little or no dialogue in the low-performing states about how to do better or how to identify and adopt system innovations. High performers, in contrast, are characterized by strong leaders and champions who have initiated and sustained reforms over decades. These states were the early innovators of coverage expansions in the early 1990s and continue to lead the way on medical homes, care coordination and disease management, prevention and primary care, and payment reform. Interviewees from high-performing states said their states had an advantage in implementing national reform because they already have organizations in place dedicated to reform, and years of experience managing the related politics and organizational challenges.

Culture of collaboration vs. fragmentation and mistrust

Policymakers in the seven profiled high-performing states credit their states' "culture of collaboration" as the critical driver in health system performance. "We trust each other," they say, or "We work through our differences to do what is right." In some states, the process is well organized, like Vermont's Blueprint for Health. In others, like Minnesota, change emerges dynamically from "coalitions of coalitions." But leaders in the high-performing states were quick to name the values that set the terms of collaboration—a progressive political tradition in Massachusetts, a commitment to public health in Vermont, an agricultural work ethic in Iowa, and simply "the Delaware way" in Delaware. Collaboration appears to come naturally to high performers. This is consistent with the concept that social capital—levels of interpersonal trust, reciprocity, and mutual aid that facilitate collective action—is correlated with health achievement.[6]

Stakeholder interactions in low-performing states were more often characterized by interviewees as adversarial and politically charged. In the low-performing states examined, the health care markets are highly fragmented, with provider groups viewing each other as competitors. On a statewide level, there is no sense of stakeholders working together toward a common goal, although some large states have examples of collaborative efforts at the community level. Physicians and hospitals in low-performing states tend to be territorial and distrustful of each other, as well as of health plans and the public sector. Despite a great deal of financial insecurity, providers in these states are

> "We trust each other," they say, or "We work through our differences to do what is right."
>
> *Policymaker in high-ranked state describing "culture of collaboration" among stakeholders*

unwilling to collaborate to change the status quo—that is, through managed care, payment reform, or national health reform—for fear of losing more "turf."

Unlike the high-performing states, where employers are critical partners in driving overall health system performance, the business community is noticeably absent from value-based purchasing in most of the low-performing states. In some of these states, the health care leaders are the primary business leaders, which blurs the lines between health care purchasers and providers. Interviewees in several low-performing states noted that when the (non-health care) business community does get involved and provides leadership for some aspect of health system improvement, the chances of improvement go up dramatically.

The fragmentation and lack of collaboration in the low-performing states is exacerbated by misaligned reimbursement incentives. Low reimbursement rates by Medicaid and health plans, along with a largely fee-for-service payment mechanism, push providers to increase volume and utilization among insured patients, particularly for high-cost specialist services. Interviewees in these states say supply appears to create demand for services, and there are few incentives that reward efficient service delivery, good health outcomes, or effective care of the patient. In contrast, the high-performing states are among the nation's leaders in piloting payment reforms that reward integrated systems of care and value over volume. As noted earlier, on average, the higher-performing states have a higher portion of hospitals in integrated systems and higher HMO penetration rates than the low-performing states (Exhibit 6).

Transparency of price and quality information

States with high-performing health systems focus on increasing value by improving quality and controlling costs. The most important strategy to improve value, according to state officials, has been to make health information transparent to consumers and purchasers. The Commonwealth Fund's *State Scorecard* documents widespread improvement on selected quality indicators, with a national commitment to reporting performance data and collaborative efforts to improve. Price and quality transparency is a necessary prerequisite for overall health system improvement.

Most of the high-performing states support stand-alone organizations with a specific mission to collect and publicly report cost and quality information. In many states, these organizations were established by physician leaders or hospital systems to improve patient care and today function as multi-stakeholder forums to align statewide quality improvement and cost control initiatives. These organizations help to evaluate and adopt emerging best practices, establish patient-centered medical homes, exchange health information electronically, and experiment with payment reforms that reward health professionals for the quality rather than the quantity of services provided.

The low-performing states examined do not have a stand-alone organization to collect and publicly report cost and quality information. The lack of trust among stakeholders and a lack of common goals have resulted in relatively late and slow adoption of data-sharing, health information technology (HIT), and electronic health information exchange (HIE). Without good data, low performers are at a disadvantage when it comes to understanding health system status, running systems on a day-to-day basis, and planning and implementing system improvement. HIT and HIE activity is now under way in most low-performing states, but largely in response to federal incentives, not as a result of state leadership or a predisposition toward data-sharing. In contrast, high performers were early adopters of HIT and HIE, largely because data-sharing was not considered a barrier.

A congruent set of policies that focus on system improvement

States with high-performing health systems work hard to establish a congruent set of policies that continuously improve overall health system performance. In many ways, high performers start out with advantages over other states. As discussed earlier, they typically have higher per capita income and lower levels of poverty, which affect the demand for services and the financial resources available to support health services. Low performers typically have higher levels of poverty (i.e., greater demand) and lower per capita income (i.e., fewer resources). High performers also benefit from a long history of health reform. They can leverage government leadership, a culture of collaboration, and price and quality transparency into continuous health system improvement.

States play many roles that allow them to affect health policy. They purchase coverage for vulnerable populations and state employees, regulate providers and insurers, advocate public health, and convene and collaborate with other health system stakeholders. High performers embrace these roles; low performers accept them, but as a lower priority than keeping taxes low and limiting the intrusion of state government into local government or individual lives. As a result, high performers are more likely to have a congruent set of policies that focus on system improvement than are low performers.

PROMISING STRATEGIES: LESSONS FOR SYSTEM IMPROVEMENT FROM HIGH AND LOW PERFORMERS

The states examined for this brief show that very high levels of health system performance are achievable and sustainable, but many states face serious barriers to system improvement. Across the high-performing states, common strategies that other states should consider include a long-term commitment to reform, encouraging collaboration among multiple stakeholders, leadership to expand health insurance coverage through public programs, transparency of health information, and ensuring the state has the capacity to recognize and act on emerging best practices. The common themes among high-performing states and the differences between high- and low-performing states suggest the following strategies for system improvement.

Align incentives and goals to change behavior

Regardless of a state's starting place, better-aligned incentives are needed to drive practice change among consumers, providers, and health plans. Discussions confirmed that financial incentives are motivators, particularly in the current difficult economic climate. Efforts to change behavior without accompanying rewards generally failed or had limited impact.

Incentives to consumers were particularly needed in low-performing states. Health plans could incorporate meaningful financial incentives to encourage consumers to establish and stay with their primary care providers or medical homes. Incentives already practiced in some plans with limited success could be strengthened. These include rewarding consumers who engage in health promotion and self-management of chronic disease or those who select high-performing providers.

Across all states, better alignment should involve payment and delivery reforms such as bundled payments, accountable care organizations (ACOs), and other forms of pay-for-performance that reward health care providers for good health outcomes, lower readmissions, and efficiency. The payment mechanism must encourage serving patients across treatment settings. Under bundled payments, a health plan pays providers a single amount to cover an entire episode of care, unlike traditional fee-for-service that rewards volume and utilization. An ACO mechanism may allow providers to share in the savings from cost-effective care, encouraging the provision of lower-cost, preventive care and minimally invasive treatment alternatives to high-cost procedures.

National health reform, as well as existing regional, state, and federal initiatives, provides opportunities for testing and disseminating new models of payment and delivery reform.

Frame health in terms of economic development to gain public and political support

Experience in some of the poorer states suggests the importance, particularly in the current economic climate, of emphasizing potential economic development gains from public health and health system performance initiatives. This can help gain critical business, consumer, and legislative support. Interviewees in several of the low-performing states cited a prevailing attitude that being poor leads to poor health. This message, they argue, must be turned around to convey that poor health leads to being poor.

Linking health-related programs to economic development involves establishing or strengthening linkages across agencies and sectors. For example, child anti-obesity programs could involve a partnership among a state public health agency and departments overseeing education and child care, under a banner of improving student performance and a building stronger, healthier workforce. This widens the potential base of support and the pool from which champions could emerge.

Similarly, the business case needs to be made for health system performance improvement programs. Transparency initiatives such as collection and public reporting of quality and cost data, and payment reforms such as pay-for-performance should emphasize waste reduction and quality improvement in the health care industry, as well as enhanced productivity in the general workforce as health outcomes improve. States should partner with private providers to test telehealth and e-referral services and evaluate their impact on access and practice efficiency. Program planners need to estimate and then show return on investment. Current pilots around the country are providing models and data to help make the case.

Engage purchasers and payers to drive value and quality improvement

To date, employers have not been active or are just beginning to engage in value-based purchasing in low-performing states, although they played a significant early role among high performers. Interviewees in several of the high-performing states described how business leaders and employers in the early 1990s put pressure on employers and providers to improve the value of services. In turn, that pressure drove new initiatives related to price and quality transparency and early versions of payment reform like pay-for-performance. Recently private purchasers (e.g., large employers, unions) as well as public purchasers (e.g., Medicaid, state employee benefit agencies) have been experiencing unrelenting increases in their health benefit costs and have much to gain from greater efficiency and quality in the health system.

State leaders and planners can engage purchasers and payers to play a greater role; for example, they can encourage a neutral organization to act as facilitator and present examples of purchaser and payer success in improving value. Medicaid and state employee and retiree programs could be leaders in driving value by expecting and demanding transparency, value-based insurance design, and quality reporting and incentives in their contracts with health plans and health care systems.

Bring stakeholders together to develop goals and build trust

The experiences of high- and low-performing states underscore the importance of bringing stakeholders—physicians, hospitals, health plans, purchasers, employers, consumers, Medicaid, other state government representatives—together to develop common and realistic goals and to take action toward reaching them. Initiatives have a better chance of success when the various players are on board and focused on a common purpose rather than on undermining each other. The process itself can help reduce past tensions.

This is no easy task, particularly in states that do not have any history of collaboration. It may require a neutral party such as a Quality Improvement Organization or state-based health foundation, to initiate, facilitate, and host meetings. Alternatively, many states have implemented multi-stakeholder national reform implementation task forces or councils.[7] These

bodies may provide the venue or starting point for collaboration. The effort should begin with setting modest goals, particularly when there is little optimism about what the state can accomplish. Early, small victories can boost confidence and camaraderie on which to build new goals and efforts. State planners must acknowledge, however, that building trust among groups that are historically suspicious and at odds with each other is a slow and painstaking process.[8]

The current state fiscal crisis appears to have two different effects. It could cause greater insecurity and lead people to dig in their heels, afraid they might lose the little they have. For example, a provider association receiving inadequate Medicaid reimbursement rates may oppose a payment reform pilot program fearing that their constituents may wind up with even lower payments. Or, the fiscal crisis may lead to the realization that the status quo is not sustainable and the only way to survive is to work together and change the way everyone practices and behaves. It takes leadership, perseverance, data, and examples of success to sway others from the former attitude toward the latter. An aggressive federal reform timetable could also be a catalyst for collaboration and change.

Take advantage of federal funding, incentives, and reform opportunities

The lack of available state resources highlights the need for federal funding and requirements that can drive participation in activities to improve health system performance. Federal grants and incentive payments are already stimulating movement among states and stakeholder groups that have rejected change in the past. The federal incentive payments to providers to set up electronic health records and attain meaningful use, along with federal American Recovery and Reinvestment Act funds to states to accelerate the adoption of HIT and HIE, are driving new activity among public and private entities. Federal grants could promote collaborative efforts further by requiring participation by stakeholder coalitions.

National health reform has been a wake-up call, providing numerous new additional funding and incentives opportunities to drive participation in activities that may improve health system performance. The scope is unprecedented, with new opportunities and requirements for states to:

- expand coverage through a significant Medicaid expansion, new health insurance exchanges, and insurance market reforms;
- reform the health care delivery system through value-based purchasing reforms that encourage patient-centered prevention and primary care and integrated services;
- ensure access to providers through provider reimbursement strategies, workforce development, and special safety-net programs; and
- provide the information required to make better decisions through price and quality transparency and HIT and HIE initiatives.

Notes

1 For more information, see D. McCarthy, S. K. H. How, C. Schoen, J. C. Cantor, and D. Belloff, *Aiming Higher Results from a State Scorecard on Health System Performance, 2009* (New York: The Commonwealth Fund, Oct. 2009).

2 G. Moody and S. Silow-Carroll, *Aiming Higher for Health System Performance: A Profile of Seven States That Perform Well on the Commonwealth Fund's 2009 State Scorecard* (New York: The Commonwealth Fund, Oct. 2009).

3 The Henry J. Kaiser Family Foundation, http://www.statehealthfacts.org.

4 In Illinois, parents are covered to 191% FPL for Medicaid and 200% FPL for premium assistance. In New Mexico, more limited coverage and premium assistance were available to parents and childless adults with income above the poverty level, however enrollment is currently closed. See Kaiser Family Foundation, http://statehealthfacts.org/comparereport.jsp?rep=54&cat=4.

5 Kaiser Family Foundation, http://statehealthfacts.org/comparemaptable.jsp?ind=183&cat=4&sub=47A.

6 A 1997 analysis of a 39-state survey found a close correlation between social capital and health, and that the level of trust explained 58 percent of the variance in total mortality across states. See I. Kawachi, "Social Capital and Community Effects on Population and Individual Health," *Annals of the New York Academy of Sciences,* 1999 896:120–130.

7 D. Love, W. Custer, and P. Miller, *All-Payer Claims Databases: State Initiatives to Improve Health Care Transparency* (New York: The Commonwealth Fund, Sept. 2010).

8 For a discussion of the measurement of social capital and links to public health, see I. Kawachi, S. V. Subramanian, and D. Kim, eds., *Social Capital and Health* (New York: Springer, 2008).

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Sharon Silow-Carroll, M.B.A., M.S.W., is a health policy analyst with more than 20 years of experience in health care research. She has specialized in health system reforms at the local, state, and national levels; strategies by hospitals to improve quality and patient-centered care; public–private partnerships to improve the performance of the health care system; and efforts to meet the needs of underserved populations. Prior to joining Health Management Associates as a principal, she was senior vice president at the Economic and Social Research Institute, where she directed and conducted research studies and authored numerous reports and articles on a range of health care issues.

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