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In This Issue

Researchers find lower-quality care in Medicaid plans in controversial study

Harvard University researchers say Medicaid managed care enrollees receive lower quality care than that received by commercial managed care enrollees. But a spokesman for Medicaid managed care plans questions the study results, saying it's not fair to compare Medicaid and commercial populations.

According to research by Harvard Medical School Department of Health Care Policy professor **Bruce Landon**, MD, MBA, MSc, and colleagues, enrollment in Medicaid managed care more than tripled between 1994 and 2004, from 7.9 million beneficiaries to more than 27 million beneficiaries. The proportion of Medicaid beneficiaries in managed care increased from 23% to more than 60% in that decade.

With so many Medicaid recipients in managed care, it's important to evaluate the quality of the care they receive. Dr. Landon says managed care's impact on quality for the Medicaid population has been controversial. "HMOs may incorporate prevention and routine care to prevent serious and costly downstream complications and use population-management techniques to improve the delivery of service to their

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The evolution is now: P4P programs undergo 'dramatic shift' from process to outcomes

Pay-for-performance (P4P) programs are undergoing a striking transformation, moving from a focus on processes of care to one emphasizing patient outcomes, cost efficiency, and use of information technology, researchers are finding.

Fiscal Fitness: How States Cope

Investigators who surveyed 27 early adopters of P4P to assess evolution of their payment reward systems between 2003 and 2006 found that performance measures used to evaluate and reward physicians and hospitals are indeed, subject to change. For example, the study found a sharp increase in use of outcome measures to reward physician and hospital behavior, and less focus on processes such as keeping mammography screening rates high. In 2003, sponsors representing 59% of enrollees targeted health outcomes but by 2006 94% did. P4P adopters now are basing rewards on such things as whether diabetes patients actually attain healthy cholesterol levels and blood pressure rates and not just whether a doctor has

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Study

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enrollees," he says. "These techniques may be especially helpful to Medicaid recipients. State Medicaid programs also have adopted a variety of value-based purchasing techniques that require Medicaid managed care plans to measure and report on performance on core quality indicators and to undertake efforts to improve performance. Nevertheless, health plans may institute programs or procedures that limit access to necessary medical services. The poorly educated, low-income, and immigrant populations often served by Medicaid health plans likely have less ability to negotiate the sometimes complex requirements of managed care systems."

The researchers say that while Medicaid-only managed care plans may be able to provide superior care compared with commercial plans that also cover Medicaid populations but do not solely tailor services to that population, concerns have been raised about the quality of care delivered in Medicaid-only plans.

There is a concern, they say, that because many Medicaid health plans are regional plans, they may be undercapitalized, inexperienced in quality management, or rely on networks of lower-quality providers.

Dearth of peer-reviewed research

And despite considerable interest from state and national policymakers and advocates, there has been almost no information in peer-reviewed journals on the quality of care delivered within health plans to Medicaid enrollees, how that quality compares with that received by their commercial enrollee counterparts, and how the type of plan (Medicaid-only or Medicaid/commercial) makes a difference.

For their evaluation, the researchers examined performance on Healthcare Effectiveness Data and Information Set (HEDIS) quality indicators in three types of managed care plans—Medicaid-only plans, commercial-only plans, and Medicaid/commercial plans. They compared quality performance for the Medicaid and commercial populations by comparing plans that focused exclusively on one or the other population with plans that provided care for both populations.

Services evaluated included childhood immunizations, adolescent immunizations, breast cancer screening, cervical cancer screening, chlamydia screening, controlling high blood pressure, glycated hemoglobin testing in diabetes, glycated hemoglobin control to under 9%, use of appropriate medications for asthma, timeliness of prenatal care, and appropriate postpartum care.

Among the 383 health plans included in the study, 326 plans contributed commercial data and 137 contributed Medicaid data. The commercial-only population was served by 204 health plans, 37 plans served only the Medicaid population, and 142 served both commercial and Medicaid clients.

Most health plans serving only the commercial market were for-profit (77.9%); whereas 51.4% of the health plans serving only the Medicaid market were for-profit. Plans studied were well distributed around the country. A higher proportion of Medicaid and Medicaid/commercial plans were independent local plans (62.2% and 52.8%) as compared with 27.5% of commercial-only health plans. Most plans serving the commercial population (including those also serving Medicaid clients) had been in operation for more than 10 years, while most

Medicaid-only plans were less than 5 years old.

Similarities and a glaring difference

The researchers say they found little difference in the quality of care provided to the Medicaid population served by Medicaid-only plans compared with the quality of care provided to the Medicaid population served by commercial plans that also served Medicaid enrollees. Similarly, they say, there was very little difference in quality provided to commercial populations served by commercial-only plans compared with that provided to commercial populations served by Medicaid/commercial plans.

"In contrast," they say, "compared with the commercial population, the quality of care was substantially lower for the Medicaid population, regardless of plan type (with the exception of chlamydia screening). These findings suggest that the type of health plan enrolling the population is a less important determinant of the quality of care than differences in the characteristics of the population being served, the local provider networks in which they receive care, access to care, patterns of care-seeking, and adherence to treatment recommendations."

The researchers say the differences they observed between the quality performance for commercial and Medicaid enrollees both were statistically and clinically significant. Thus, cervical cancer screening rates and rates of diabetes control were more than 15 percentage points higher for commercial populations. They say further that analyses completed by the National Committee for Quality Assurance (NCQA) suggest that differences in hemoglobin A_{1C} control of an even smaller magnitude within commercial health plans could result in up to 15,000 fewer deaths per year nationally. "Thus," they contend, "there is a clear opportunity for improving the health care and health of individuals cared for in Medicaid managed care."

Interestingly, they say, chlamydia screening is the only measure showing higher performance in the Medicaid population vs. the commercial population. Factors affecting performance on this measure include physicians' perceptions about the prevalence of infection in their patient populations and outreach efforts to teenagers and young adults who may be covered under their parents' insurance policies. Higher performance in Medicaid programs, they say, may be a result of Medicaid recipients being more likely to be treated in clinics where sexually transmitted disease screening is routinely implemented or where clinicians have more accurate understanding of the prevalence in that particular population.

Socioeconomic challenges

"These differences in quality performance also underscore the challenge of delivering high-quality care to the Medicaid population," the researchers say. "Patients enrolled in Medicaid are socioeconomically disadvantaged and may face additional competing needs that make adhering to treatment recommendations difficult. Our findings suggest that mainstreaming Medicaid beneficiaries by enrolling them in health plans that also offer commercial insurance products does not appear better or worse than enrolling them in Medicaid-only health plans. While we found that performance in Medicaid/commercial plans was marginally higher than that for Medicaid-only plans on 10 of the 11 measures, those results were not statistically significant. In our previous research, we found that health plans that focus predominantly on the Medicaid population have additional outreach services aimed at the special needs of the Medicaid population. Our data here suggest that these additional services might not be sufficient to bring the quality of care for the Medicaid population up to the level received by commercial populations for routine quality indicators such as those in HEDIS, although we were not able to assess the specific outreach programs of the plans in our study."

According to the researchers, while HEDIS performance was similar across different types of health plans, the patterns observed might be explained in some part by the settings in which patients obtain care. Thus, disadvantaged patients covered through Medicaid might receive care from doctors or hospitals of generally lower quality. Presumably, the researchers say, these physicians would be included in both Medicaid-only plans and those that serve the Medicaid and commercial populations, since performance was similar across those types of plans.

Thus, even to the extent that delivery systems overlap, enrollees may still see different clinicians based on segregation of residence by socioeconomic factors. Also, many physicians refuse to participate in health plans that serve the Medicaid population, so the delivery networks might not always overlap.

A few matters of contention

Study limitations cited by the authors are important to those who disagree with the study conclusions. First, the researchers say, socioeconomic characteristics of enrolled populations are known to be associated with the quality of care and therefore could be an important confounder since commercial and Medicaid health plans enroll populations that differ on those characteristics.

At the least, they say, the results show that the alternate types of

managed care plans do not make a difference in the quality of care for Medicaid enrollees, who seem to be at risk for receiving lower-quality care than the commercial populations.

Second, not all health plans in the country report data to NCQA, although the study plan sample included the vast majority of health plan enrollees nationally.

Third, not all health plans could be linked immediately to the health plan characteristics obtained from the Interstudy Competitive Edge 8.2 2002 release that reflected data from 2001 and contained additionally updated information on HMOs in the U.S. The researchers say they did additional Internet and telephone call follow-up but were not able to obtain all relevant variables for each plan.

Fourth, although quality indicators from several care domains were included, the data include a limited number of process measures of quality and may not represent many of the dimensions of quality of care provided by health plans.

Finally, while the analyses document performance problems in Medicaid managed care, no similar information is available on care provided through traditional fee-for-service Medicaid. Thus, it is not known whether enrollees served by Medicaid health plans are receiving better or worse care than Medicaid beneficiaries not enrolled in Medicaid managed care.

The researchers conclude that if reducing disparities in health care nationally is an important goal of the U.S. health care system, "managed care is not a panacea. Additional resources will need to be devoted to designing and implementing specific interventions to improve the quality of care for Medicaid beneficiaries enrolled in managed care."

The study limitation cited by the researchers in terms of not always accounting for population socioeconomic differences resonates with America's Health Insurance Plans (AHIP) spokesman **Mohit Ghose**. "It's clear that the Medicaid population is one of the most difficult populations to serve," he tells *State Health Watch*. "But Medicaid managed care plans have never shrunk from taking on that challenge. We enroll members in needed health services and see improvements in health status."

An inappropriate comparison?

Ghose says it's inappropriate to compare the Medicaid population with a commercially insured population. He says a more appropriate analysis would be to compare Medicaid managed care with Medicaid fee-for-service, but that comparison has never been made.

"Our members are doing the work," Mr. Ghose declares. "We can show improvement in Medicaid managed care, with some years better and some worse and some measures better and some worse. It varies with the population being served until you hit a plateau."

He cites a March 2006 study in Maryland that found that Medicaid beneficiary access to ambulatory care was 20% higher through managed care than fee-for-service. In addition, he says, there were 36% more well-child services provided.

And a March 2006 New York State study found that Medicaid managed care beneficiaries were more likely to receive several critical preventive services.

Mr. Ghose says in the latest NCQA survey, Medicaid managed care plans made gains in 34 of 43 quality measures compared with last year.

His final example is Kentucky, which has seen a 247% increase in EPSDT (Early Periodic Screening Diagnosis and Testing) since Medicaid managed care began and a 162% increase in childhood immunization rates.

"You find that almost across the board Medicaid managed care is providing higher quality care than Medicaid fee-for-service," Mr. Ghose concludes.

The Harvard study appeared in the Oct. 10, 2007, issue of the Journal of the American Medical Association. *E-mail Dr. Landon at Landon@hcp.med.harvard.edu. Telephone Mr. Ghose at (202) 778-8494.* ■

Fiscal Fitness

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prescribed pills.

"This is a pretty dramatic shift," says **Meredith Rosenthal**, PhD, the lead author of the study and associate professor of health economics and policy at the Harvard School of Public Health. "These kinds of outcomes are much more meaningful than process measures of quality for capturing health status and predicting important outcomes including major adverse events such as heart attacks and death."

Dr. Rosenthal and her colleagues also found increasing numbers of P4P plans using cost-efficiency measures as a target for rewarding physicians and hospitals. In 2003, they report, sponsors representing 60% of enrollees included cost-efficiency measures as a prominent aspect of their P4P arrangements. By 2006, sponsors representing 92% of enrollees were using cost of care to measure a physician's performance score."

"This is a very significant change," Dr. Rosenthal says. "But it may also jeopardize the credibility of

these programs" because physicians may only see them as a means of cost control.

Most programs still continuing

The researchers interviewed respondents for 27 early adopter programs and found that 24 were still offering P4P. Of the three programs that were closed, one was canceled because of a perception that its market share was too small for the payment incentives to influence the targeted physicians. In another, the provider organization that had been at the center of P4P left the health network. And in the third instance, the program was terminated after a three-year pilot and a replacement was not yet in place, although it was expected that one would be developed.

Sponsors of the 24 surviving programs were geographically diverse and varied in size from 52,000 enrollees to 11 million enrollees.

Although primary care physicians continue to be the most common provider type subject to P4P, the inclusion of specialists increased between 2003 and 2006. Cardiologists and general surgeons were the most commonly mentioned specialists included in P4P programs, although gastroenterologists and orthopedists also were mentioned by several sponsors. The biggest barrier to enrolling more specialists, sponsors said, is the lack of appropriate nationally accepted quality measures. Sponsors also said attributing patients' receipt of recommended care or outcomes to specific physicians is more difficult with specialists than with primary care physicians.

For physicians and medical groups, Dr. Rosenthal says, the most commonly targeted outcome measures were intermediate outcomes such as HbA_{1C}, LDL cholesterol, and blood pressure control. For hospitals, complication and in-hospital mortality rates were frequently targeted. With some exceptions, the measures incorporated into early adopters' P4P schemes revealed a focus on chronic illness treatment guidelines and preventive medicine. In particular, all sponsors interviewed by the researchers incorporated indicators of compliance with diabetes or asthma care guidelines, and most also included process measures aimed at recommended preventive services.

Performance measures added

Programs covering 99% of enrollees had increased the total number of measures that were factored into calculating performance bonuses or withholds since 2003. In addition to supplementing measures, respondents representing 33% of enrollees said they had eliminated measures from their programs. Thus, patient satisfaction scores were dropped by three sponsors (17% of enrollees). Two said they dropped the measure because of a lack of variation in scores across providers, while a third dropped it because of the expense of collecting patient survey data. Some payers also reported eliminating these measures because scores were consistently very high: counseling for tobacco cessation, well-baby and well-child visits, mammography, cervical cancer screening, colorectal cancer screening, and combination measles, mumps, and rubella vaccination.

The majority of programs (covering 58% of enrollees) have boosted the pool of money available for performance-based pay, even after accounting for the fact that more providers are often being drawn into the program. P4P bonuses typically were about $1.40 per member per month and ranged from 20 cents to $15 per member per month. Still, despite reported increases since 2003, P4P thus remains a very small portion of total provider payments.

Interestingly, only three of the programs surveyed have been formally evaluated by independent researchers. For one, the evaluation was still continuing with no results available, while another that found improvements in hospital process and outcome measures did not have a control group. The third study found statistically significant improvements in diabetes, mammogram rates, and coronary disease measures compared with a control group, but was not able to determine whether to attribute the improvements to the incentives or to the education and direction that accompanied that program's launch.

Too early to see change?

Several sponsors said it is still too early to expect changes in performance. It also was widely acknowledged that the dynamic nature of P4P) arrangements, coupled with shifts in benefit design, public reporting, and other aspects of the health system, makes identification of P4P's impact challenging, if not impossible. Where some type of evaluation had been undertaken, Dr. Rosenthal says, outcomes were arguably positive. Respondents covering 38% of enrollees reported solid gains, with another 42% finding mixed results, and 20% finding no effect. Clinical areas where improvement was documented included diabetes care, cancer screening, and inpatient cardiac care.

"Lacking strong evidence of impact on quality improvement," Dr. Rosenthal says, "most respondents reported that their programs were sustained by at least one of three motivations. The first is a belief that if P4P is not yet improving quality, it is because they have yet to find the right technical specification and that if they keep tweaking the

program, by adding money, coordinating with other payers' P4P programs, or changing the targeted measures, they will eventually formulate an effective program. The second motivator is a sense that even if P4P is not helping improve quality, paying more for higher quality is simply fairer than paying solely for the quantity of services provided. And the third motivator is a desire to use P4P as an intermediary step toward other goals, such as making performance transparent to consumers and purchasers or developing a tiered payment system."

All 24 sponsors still running programs told the researchers they intended to continue with the approach in the near term. Indeed, Dr. Rosenthal says, 14 of them anticipated expanding use of P4P across their provider networks and four explicitly mentioned plans to increase the share of payments to be allocated based on performance.

Is there a long-term role for P4P?

However, she reports, there were two distinct and opposing camps on views on the long-term role that P4P should play. While one group expected that some form of P4P would become a permanent reimbursement system feature, an opposing group took the view that the regulatory P4P model would give way to a health care market where both consumers and payers would be able to distinguish high-value from low-value providers and that high-value providers would be able to command a price premium. Members of that group said they firmly believed in the power of publicly-reported provider performance data. In fact, Dr. Rosenthal says, three sponsors identified performance data transparency as a more important lever for performance improvement than payment incentives. In contrast, she says, four sponsors expressed serious doubts about the public's ability to understand health care quality and efficiency reports.

Respondents identified three major challenges to building and maintaining effective P4P programs: 1) overcoming physician resistance; 2) determining the necessary size of incentive pools to capture providers' attention; and 3) finding resources necessary to continue program funding.

When the researchers ask them what lessons they had learned from their P4P experiences, some respondents focused on the importance of promoting provider involvement as a means of reducing opposition to the programs. The second most prevalent lesson noted was in the area of selecting measures. Thus, four respondents stressed the importance of using clinical rather than administrative data, in part to overcome physicians' concerns about the validity of performance measurement. Four sponsors also cited the need to use only nationally accepted measures such as those approved by the National Quality Forum so that physicians will be satisfied and there can be coordination with other programs.

Five respondents said the most serious threat to P4P sustainability was the absence of a demonstrable return on investment. Although only three sponsors had documented a return on investment, another five said quantifying such a net savings was a future goal.

It's time to evaluate

Dr. Rosenthal says her findings yield several important implications for policy, practice, and research. First, as early adopters have increased levels of payment and migrated to health outcomes and costs as targets, there is a need to add evaluation to program design. "Program evaluation could assess both the impact of the programmatic changes on targeted measures and unintended, adverse consequences," she says. "With increasing focus on outcomes and cost, we also need better risk adjustment to address real and perceived outcomes about patient differences that might undermine quality incentives."

Second, she says, many early P4P adopters have made efforts to strengthen their programs by increasing the size of the incentive pool, although such increases remain modest in terms of the dollars paid out. Some sponsors have also begun to reward improvement explicitly, alongside attainment of benchmark performance levels.

Finally, expansion in the comprehensiveness of measure sets among early adopters means there is less latitude for providers to focus on a single population group or condition to maximize P4P payments. Theoretically, she says, that should motivate more holistic approaches to quality improvement, which are viewed by many as critical to making real progress in achieving national quality goals.

"Despite the increasing scope of measurement, the range of measures and conditions covered by the P4P programs we studied remains relatively narrow," Dr. Rosenthal says, "largely because of the limits of current measure sets. P4P may become important in those clinical domains for which there is, or will be, sufficient evidence to support meaningful progress or outcome measurement. However, it should probably be acknowledged that some areas of medicine, for example, where patients' preferences greatly affect the appropriate course of treatment, may never be well suited for performance incentives."

The research also highlighted developments that could undermine

P4P. Dr. Rosenthal says many respondents were focused on making a business case for P4P, a concern that she says is clearly driven by employers that are alarmed at the continued pace of rising health insurance premiums. Although efficiency is an important component of quality, she says, emphasis on reducing the cost of care may ultimately undermine the credibility of these programs with physicians and other stakeholders.

Dr. Rosenthal tells *State Health Watch* that quality measures have been an issue for physicians since P4P began. "It's hard to sort through what people are really thinking," she says. "Orienting P4P around weak quality measures is problematic." She says she finds it encouraging that there has been a dramatic increase in resources and attention paid to quality measures.

Dr. Rosenthal candidly recognizes that even better quality measures might not make doctors any more receptive to P4P. "No one wants to be measured," she says, "especially when they are found lacking. It is a shared concern, so it is productive to focus on it."

Asked about the relative lack of program evaluations to date, Dr. Rosenthal says evaluating them is as possible now as it will ever be, and that many of the programs have been in place enough time for an evaluation to be done. "Some programs are robust enough that we can assume there has been some effect," she says. "We need a better understanding of what strategies are most effective. I worry that people think P4P is a good idea but don't learn from their mistakes."

While Dr. Rosenthal believes P4P programs can be generalized and applied to different locations, she recognizes that in some markets with monopolies, it may not be possible to negotiate P4P contracts. "The main limitation is the extent of payer fragmentation," she says.

Can P4P be cost-effective?

The biggest threat Dr. Rosenthal sees to future success of P4P programs is the need to be cost-effective. "We are desperate to find ways to reduce health care costs," she says. "It is the central challenge for U.S. health policy. But we are equally desperate to improve quality. And pay-for-performance is saddled with these twin problems. An emphasis on cost could jeopardize doctors' willingness to participate. I wonder if there are other strategies more appropriate for cost control so P4P could be left for quality improvement."

Dr. Rosenthal projects that five years from now P4P programs will look much as they do today. She says they may represent a somewhat higher percentage of total payments to providers. They still will have mostly process measures and intermediate outcome measures. She hopes there will be decent quality measures for a wider range of physician specialties. She anticipates more case rate payments and more groups taking full capitation.

"It will be a good thing if programs are similar to today's and are routine," Dr. Rosenthal says, "as long as they have valid performance measures used for payment. They don't have to be perfect performance measures. It's OK if they are good enough for 10% to 15% of total payment. It's not necessary to put 25% into P4P. It will be good if P4P programs can continue to operate and we can get on with the agenda to create a more sustainable health care system."

The study appeared in the November/December 2007 issue of Health Affairs. *Contact Dr. Rosenthal at (617) 432-3418 or e-mail mrosenth@hsph.harvard.edu.* ■

Child care deficits could lead to preventable adverse outcomes

There are deficits in delivery of indicated care to children that are similar in magnitude to those that have been reported for adults, according to new research conducted by RAND, the University of Washington, Seattle Children's Hospital and Regional Medical Center, and the University of California at Los Angeles.

Lead researcher **Rita Mangione-Smith** tells *State Health Watch* there has been an assumption for many years that the quality of care for children is quite good. "But that's not a fair assumption unless quality is being measured," she says. "And we haven't been measuring. Because we have not been measuring quality regularly and reporting on performance, people think it's just fine."

But the researchers say the deficits may result in avoidable adverse health outcomes. For example, they say, only 44% of children with asthma who were noted to be using beta-agonists at least three times per day had a prescription for an anti-inflammatory medication recorded in the chart. Similarly, studies of children with persistent asthma have shown that only 39% to 51% were treated with anti-inflammatory medications. Children with persistent asthma who are treated with inhaled anti-inflammatory drugs, as compared with those who are not, have fewer asthma-related symptoms and improved pulmonary function, are hospitalized less frequently, and have lower asthma-related mortality.

Likewise, immunizations are effective in protecting children against a variety of serious childhood

diseases. But only 49.8% of children in the study who reached 2 years of age during the study period were fully immunized, according to their records.

According to chart data, urine cultures were obtained for 16.2% of children aged 3 months to 36 months who presented with fever of unknown origin and who were thought to be at high risk for sepsis. The reported prevalence of urinary tract infection is high (4% to 5%) among children 2 months to 2 years of age who have fever without an identified source of infection on the basis of the history and physical examination, the researchers said. Early diagnosis of urinary tract infection might lead to earlier identification of high-grade vesicoureteral reflux, allowing for prevention of recurrent infections, worsening renal damage, and chronic renal failure.

Chlamydia screening down

Only 41.5% of eligible adolescent girls in the study had charts showing evidence of laboratory orders for teats for *Chlamydia trachomatis* or the results of such testing, as compared with 37% of adolescent girls enrolled in Medicaid and 24% of those with commercial health insurance, according to HEDIS data from 2000. The researchers said chlamydia screening is important because 75% of such infections are asymptomatic and it is reported that 40% of untreated women and adolescents will have pelvic inflammatory disease. Of that 40% of women, 20% will have infertility due to tubal factors and 9% will have life-threatening complications during pregnancy. The researchers said broad-based screening, early detection, and treatment have decreased incidence of pelvic inflammatory disease associated with chlamydia in adolescent girls by 60%, lowering rates of hospitalization and complications.

The researchers said this study has been needed because quality problems so far have been documented mainly from studies of care delivered to adults and the elderly. Previous studies of children have examined few quality measures; have involved self-reported data from parents, patients, or providers; or have been limited to Medicaid enrollees or to a particular geographic region.

"Research and policy related to children have focused on expanding eligibility for public insurance programs, but expanding access to a system that does not deliver necessary services will not result in optimal outcomes," the researchers say. "Deficits in the delivery of care must be identified if appropriate strategies to close the gaps are to be developed and implemented," they point out.

Using a RAND comprehensive method for evaluating quality on the basis of information in medical records, the researchers sought to answer five questions: 1) How good is the quality of care for children overall? 2) Does quality vary according to the type of care (care for acute or chronic medical problems or preventive care)? 3) Does care vary across the continuum of care functions (screening, diagnosis, treatment, and follow-up)? 4) Does quality vary according to the mode of care (history taking, physical examination, laboratory testing or radiography, medication, immunization, encounter, education, or counseling? and 5) Does quality vary according to the type of clinical area?

The researchers say a potential limitation of their work is that the data on which the results are based are 7 to 11 years old, which raises the question of whether today's practice patterns are different. "Although the data in this study are based on recorded care delivered from 1996 to 2000, it seems unlikely that quality has improved substantially since that period," they conclude. "Expansion of access to care through insurance coverage, which is the focus of national health care policy related to children, will not, by itself, eliminate the deficits in the quality of care."

Ms. Mangione-Smith says leadership for improving health care quality for children must come from a number of areas through a multifaceted approach. First, she says, doctors should assess what they are doing to deliver care in their offices and ask if there is anything they should change or standardize.

One technique that works, she says, is to use structured encounter forms that provide triggers to prompt doctors to ask certain questions during a well-child visit, such as safety issues, immunizations, developmental issues, and screening tests.

Another answer, she says, is to build a better information technology infrastructure in physician practices so reminder notices can be automatically generated and sent to patients when checkups or other medical services are due.

Ms. Mangione-Smith says office visits are currently too short for doctors to have enough time to cover everything that should be covered and allow parents an opportunity to talk about concerns and ask questions. Insurers need to realize their payments are the same no matter how much time the doctor spends, she says, and thus doctors are being incentivized to see more patients rather than to provide high-quality care. "We need to incentivize high-quality care and spending enough time," she declares. She also believes insurers should make sure there is continuity of care when people change jobs and are told they can no longer visit the provider who has been treating them.

A third area to be addressed, according to Ms. Mangione-Smith, is training of physicians. She says their training focuses on acute illness care

rather than prevention and wellness. "Most doctors' training time in hospitals involves taking care of very sick kids," she says, "and they learn to do that very well. But they need to learn how to take care of basically well children in an outpatient setting. Our training today is kind of backwards."

Most people who have responded to the study have seen it as a "serious call to action," Ms. Mangione-Smith says, noting there could have been a defensive response from medical professionals but that has not happened. Pediatrics groups, she says, have indicated they see the results as a significant problem that must be addressed.

"I have a great hope about what we're capable of doing," Ms. Mangione-Smith concludes. "But we have a lot of work ahead of us."

Download the study at http://www.nejm.org. Contact lead researcher Rita Mangione-Smith at (206) 221-6631 or e-mail ritams@u.washington.edu. ■

Tobacco prevention spending: Will progress go up in smoke?

States have increased funding for tobacco prevention and cessation programs by 20% to $717.2 million for fiscal year 2008, but that's still less than half of the expenditure recommended by the Centers for Disease Control and Prevention (CDC).

An analysis of the resources committed to the programs was released at year's end by a coalition of public health organizations that warned that with smoking rates at a standstill after nearly a decade of decline, the nation's progress in reducing smoking is at risk unless states significantly increase funding for programs to prevent children from smoking and help smokers quit.

The report, "A Broken Promise to Our Children: The 1998 State Tobacco Settlement Nine Years Later," was released by the Campaign for Tobacco-Free Kids, American Heart Association, American Lung Association, and American Cancer Society Cancer Action Network.

The report found that only Maine, Delaware, and Colorado currently fund tobacco prevention programs at CDC minimum levels. Meanwhile, only 17 other states fund programs at even half the CDC recommended level, and 30 states and the District of Columbia are spending less than half the CDC minimum, while Connecticut is alone in not appropriating any funding for tobacco prevention this year (**see chart, pp. 10-11**).

One key reason for the increase in funding is that Florida went from $1 million last year to $58 million this year as a result of a state constitutional amendment initiated by public health organizations that requires the state to spend 15% of its annual tobacco settlement revenue on tobacco prevention. The report says the amendment restores funding for what had been one of the nation's most effective and innovative tobacco prevention programs and gives Florida the opportunity to again be a national leader if it properly implements its program.

Other states that increased funding for tobacco prevention programs include Indiana, Iowa, Oklahoma, South Dakota, Tennessee, and Wisconsin, although most remain below CDC's recommendations.

The groups say total state funding for tobacco prevention amounts to less than 3% of the record $24.9 billion the states will collect this year from the tobacco settlement and tobacco taxes. And just 6.4% of this tobacco revenue would fund prevention programs in every state at CDC minimums.

"The states' funding of tobacco prevention pales compared to the $13.4 billion a year spent on tobacco marketing and the nearly $100 billion spent each year on health care bills due to tobacco use," the report says.

The report was issued as recent surveys have found that the nation's progress in reducing smoking has stalled among both youth and adults. CDC has reported that 20.8% of adults smoked in 2006, about the same as the 20.9% in 2004 and 2005. That followed a steady decline between 1997 and 2004. High school smoking rates have similarly stalled after declining from a high of 36.4% in 1997, and 23% of high schoolers still smoke, according to CDC data. CDC attributed the stall to several factors, including cuts in tobacco prevention funding, increases in tobacco marketing, and stagnant cigarette prices due to industry discounting.

"The states' failure to do more to prevent and reduce tobacco use is especially troubling in light of recent national surveys indicating that the remarkable progress the United States has made in reducing smoking has stalled among both young and adults," the report declares. "If the nation is to continue reducing smoking and other tobacco use, Congress and the states must resist complacency and redouble efforts to implement proven tobacco control measures. These include fully funded tobacco prevention programs, higher tobacco taxes and smoke-free workplace laws at the state level, and U.S. Food and Drug Administration regulation of tobacco products, higher tobacco taxes, and a national public education campaign at the federal level."

The public health groups also say there is more evidence than ever that tobacco prevention and cessation

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FY2008 Rankings of State Funding for Tobacco Prevention

State	FY2008 Current Annual Funding (millions)	CDC's Annual Funding Recommendations (millions)	Percent of CDC Minimum Recommendations	Current Rank	FY2007 Rank
Maine	$16.9	11.19 – 23.35	151.2%	1	1
Delaware	$10.7	8.63 – 18.46	123.8%	2	2
Colorado	$26.0	24.55 – 63.26	105.9%	3	3
Hawaii	$10.4	10.78 – 23.45	96.3%	4	7
Alaska	$7.5	8.09 – 16.51	92.5%	5	10
Montana	$8.5	9.36 – 19.68	90.6%	6	12
New York	$85.5	95.83 – 269.30	89.2%	7	5
Arkansas	$15.6	17.91 – 46.45	87.1%	8	6
Arizona	$23.5	27.79 – 71.10	84.6%	9	4
Washington	$27.1	33.34 – 89.38	81.1%	10	8
Wyoming	$5.9	7.35 – 14.40	80.1%	11	9
Minnesota	$22.1	28.62 – 74.01	77.2%	12	11
Florida	$58.0	78.38 – 221.26	74.0%	13	41
Ohio	$44.7	61.74 – 173.68	72.4%	14	13
New Mexico	$9.6	13.71 – 31.95	70.1%	15	16
Vermont	$5.2	7.91 – 15.94	66.0%	16	14
Oklahoma	$14.2	21.83 – 56.31	65.1%	17	20
Iowa	$12.3	19.35 – 48.71	63.5%	18	25
Maryland	$18.4	30.30 – 78.60	60.7%	19	15
South Dakota	$5.0	8.69 – 18.21	57.5%	20	40
Pennsylvania	$31.7	65.57 – 184.76	48.3%	21	19
District of Columbia	$3.6	7.48 – 14.57	48.1%	22	42
Wisconsin	$15.0	31.16 – 82.38	48.1%	22	26
Utah	$7.3	15.23 – 33.38	47.7%	24	18
California	$77.4	165.10 – 442.40	46.9%	25	17
Indiana	$16.2	34.78 – 95.80	46.6%	26	27
Mississippi	$8.0	18.79 – 46.80	42.6%	27	51
North Carolina	$17.1	42.59 – 118.63	40.2%	28	21
West Virginia	$5.7	14.16 – 35.37	40.0%	29	22
Oregon	$8.2	21.13 – 52.84	38.8%	30	33
North Dakota	$3.1	8.16 – 16.55	38.4%	31	23
Virginia	$14.5	38.87 – 106.85	37.3%	32	24

State	FY2008 Current Annual Funding (millions)	CDC's Annual Funding Recommendations (millions)	Percent of CDC Minimum Recommendations	Current Rank	FY2007 Rank
Massachusetts	$12.8	35.21 – 92.76	36.2%	33	31
Tennessee	$10.0	32.23 – 89.08	31.0%	34	51
Louisiana	$7.7	27.13 – 71.43	28.3%	35	28
New Jersey	$11.0	45.07 – 121.33	24.4%	36	30
Nebraska	$2.5	13.31 – 31.04	18.8%	37	32
Nevada	$2.0	13.48 – 32.99	14.8%	38	29
Illinois	$8.5	64.91 – 179.05	13.1%	39	34
Idaho	$1.4	11.04 – 24.09	12.6%	40	39
New Hampshire	$1.3	10.89 – 24.77	12.3%	41	51
Texas	$11.8	103.29 – 284.74	11.4%	42	45
Rhode Island	$940,000	9.89 – 21.91	9.5%	43	35
Kentucky	$2.4	25.09 – 69.90	9.4%	44	37
South Carolina	$2.0	23.91 – 62.01	8.4%	45	38
Kansas	$1.4	18.05 – 44.69	7.8%	46	43
Michigan	$3.6	54.80 – 154.56	6.6%	47	51
Georgia	$2.2	42.59 – 114.34	5.3%	48	44
Alabama	$767,000	26.74 – 71.24	2.9%	49	46
Missouri	$200,000	32.77 – 91.36	0.6%	50	51
Connecticut	$0.0	21.24 – 53.90	0.0%	51	36

NOTE: The CDC recently updated its recommendation for the amount each state should spend on tobacco prevention programs, taking into account new science, population increases, inflation and other changes since it last issued its recommendations in 1999. In most cases, the new recommendations are higher than current ones. Next year, this report will begin to assess the states based on these new recommendations.

Source: Campaign for Tobacco-Free Kids, Washington, DC.

programs work to reduce smoking, save lives, and save money. In 2007, the Institute of Medicine, the President's Cancer Panel, and the CDC all issued landmark reports concluding that there is overwhelming evidence that comprehensive state tobacco control programs substantially reduce tobacco use. The groups all said because of their effectiveness, every state should fund such programs at CDC-recommended levels.

Beginning in 2008, the groups say, states will have a critical second chance to adequately fund tobacco prevention programs because of a provision in the 1998 multistate tobacco settlement that calls for the 46 states, the District of Columbia, and the U.S. territories that are parties to the settlement to receive "bonus" payments totaling nearly $1 billion per year. "By allocating these new windfall funds to tobacco prevention and cessation programs, states can finally keep the promise of the tobacco settlement to confront the tobacco problem," the report says.

According to the coalition, states have no credible excuses for their failure to adequately fund programs to prevent kids from smoking and help smokers quit. The report notes that when the public health problems posed by tobacco are compared to other health problems, "it is clear that the amount the states are spending on tobacco prevention pales in comparison to the enormity of the problem." Tobacco use is the No. 1 cause of preventable death in the United States, claiming more lives each year (more than 400,000) than AIDS, alcohol, car accidents, murders, suicides, illegal drugs, and fires combined. Tobacco use, the report says, costs the nation nearly $100 billion a year in health care bills. And every day, more than 1,000 kids become new smokers and another 1,200 Americans die because of tobacco use.

Not having enough money available isn't the problem, the report says. States this year will collect a record $24.9 billion from the tobacco settlement and tobacco

taxes, and just 6.4% of that total would fund prevention programs at CDC-recommended levels.

After quoting from reports issued by the Institute of Medicine and CDC demonstrating the value of prevention programs, the public health groups say the strongest evidence that tobacco prevention programs work comes from the states themselves. Maine, which has ranked first in funding tobacco prevention programs for six years in a row, has reduced smoking by 64% among middle school students and by 59% among high school students since 1997. And Washington State, which also has a well-funded prevention program, has cut smoking by 60% among sixth graders, 58% among eighth graders, 40% among 10th graders, and 43% among high school seniors.

Maine's Department of Health estimates the state's smoking declines have prevented more than 26,000 youth from becoming smokers, saving more than 14,000 of them from premature smoking-caused deaths, and already have saved more than $416 million in future health care costs. The savings estimates are based on research showing that smokers, on average, have $16,000 more in long-term health care costs than nonsmokers. Likewise, the Washington State Department of Health estimates that the state's smoking decline translates into 65,000 fewer youth smokers, 230,000 fewer adult smokers, and $2.1 billion in long-term health care cost savings.

California studies have demonstrated, according to the report, that the state's long-running tobacco prevention and cessation program has saved tens of thousands of lives by reducing smoking-caused birth complications, heart disease, stroke, and lung cancer. Lung cancer incidence has been declining four times faster in California than in the rest of the nation. And other studies have shown that California and Massachusetts, which started their tobacco prevention programs in 1990 and 1993, respectively, were saving as much as $3 in smoking-caused health care costs for every dollar spent on tobacco prevention when their programs were adequately funded.

The National Conference of State Legislatures told *State Health Watch* its policy is not to comment on reports issued by other organizations and their implications for state action. The National Governors Association did not respond to a request for comment on the report and state actions.

"Our nation has made significant progress in reducing tobacco use with a comprehensive approach that includes well-funded tobacco prevention and cessation programs, tobacco tax increases, and smoke-free workplace laws," the report concludes. "Continued progress will not occur, however, unless states use more of the billions of dollars they receive from the tobacco settlement and tobacco taxes to fund comprehensive tobacco prevention and cessation programs based on the recommendations of the CDC.

Download the report at www.tobaccofreekids.org/reports/settlements. ■